Proposed 2018 Medicare Physician Payment and Quality Reporting Changes
MGMA MEMBER-EXCLUSIVE ANALYSIS

The Centers for Medicare & Medicaid Services (CMS) recently proposed changes to both Medicare physician payment and quality reporting program policies that would generally take effect Jan. 1, 2018. On June 30, CMS published a proposed rule that would change the Merit-Based Incentive Payment System (MIPS) and alternative payment model (APM) participation options and requirements for 2018. Additionally, CMS published the proposed 2018 Medicare physician fee schedule (PFS) on July 21, 2017. MGMA will submit formal comments in response to both proposed rules and share them with members in the MGMA Washington Connection newsletter.

Executive’s Insights

2018 MIPS and APMs proposed rule highlights

- CMS would gradually increase requirements to avoid a payment cut and earn a bonus payment in MIPS.
- The agency proposes to substantially increase the low-volume threshold, which would exclude approximately 63% of clinicians from MIPS.
- Cost measures would continue to be excluded from the MIPS final score.
- Clinicians and groups would have the option to use EHR technology certified to either 2014 or 2015 standards.
- CMS proposes no new Advanced APMs but anticipates participation rates will double in 2018 due to interest in the Medicare Shared Savings Program (MSSP) Track 1+, as well as growth in the Next Generation and Comprehensive Primary Care Plus (CPC+) models.

2018 Medicare PFS proposed rule highlights

- CMS estimates the 2018 Medicare PFS conversion factor would be $35.9903 based on proposed policies.
- The Appropriate Use Criteria program would not begin until Jan. 1, 2019, and would not impact physician payment until 2020 at the earliest.
- CMS would retroactively lower PQRS and Meaningful Use reporting requirements and reduce the size and scope of 2018 penalties under the Value-Based Payment Modifier.
- The agency proposes to simplify beneficiary assignment and financial calculations for MSSP participants.

MGMA will submit detailed recommendations in response to a Request for Information about opportunities to reduce burdens on physician practices and make the delivery system less bureaucratic and complex.
Proposed 2018 changes: The Merit-Based Incentive Payment System

**MIPS SCORE AND PAYMENT ADJUSTMENTS**

Eligible clinicians (ECs) and group practices would continue to be scored in MIPS based on data in three categories: quality, advancing care information (ACI) and improvement activities. CMS proposes to keep the weight of the cost component neutral for the 2018 performance period and count quality as 60% of the final score, ACI as 25% and improvement activities as 15%.

ECs and group practices would need to earn at least 15 out of a possible 100 percentage points in 2018 to avoid a Medicare payment cut of up to 5% in 2020. This is an increase from the current threshold of three points but could be achieved by satisfying the requirements of one MIPS category or subparts of multiple MIPS categories. For instance, clinicians that participate fully in the improvement activities category would receive 15 points and avoid a penalty.

ECs and groups earning more than 15 percentage points would be eligible for a slight bonus payment in 2020. Those earning 70 points or more would earn an additional bonus between 0.5 and 10%. CMS proposes to add five points to the final score of solo practitioners and group practices consisting of 15 or fewer clinicians who submit at least one data point. CMS would add up to three percentage points to the final score of ECs and groups who treat complex patients.

**LOW-VOLUME THRESHOLD**

CMS proposes to increase the low-volume threshold that excludes certain ECs and groups. The current threshold is $30,000 or less in Medicare Part B charges or 100 or fewer Medicare beneficiaries. For the 2018 performance period, CMS proposes to exclude ECs and groups that bill $90,000 or less in Medicare Part B charges or see 200 or fewer Medicare beneficiaries. The agency projects 585,560 clinicians would fall below this threshold and therefore be excluded from MIPS. CMS seeks input regarding an option for excluded ECs and groups to voluntarily participate in MIPS and receive payment adjustments.

**MIPS REPORTING POLICIES**

ECs and groups would be required to report a minimum of 90 consecutive days of data for ACI and improvement activities but would need to submit 12 months of quality measure data in 2018. MGMA has been extremely critical of full-year reporting and will advocate strongly for a reduction in the quality measure reporting period for 2018.

CMS proposes to score measures within a performance category when submitted via multiple mechanisms, except CMS Web Interface. For instance, if finalized, a group could submit two quality measures via qualified registry and four via EHR to satisfy the quality reporting criteria.

**CERTIFIED EHR TECHNOLOGY (CEHRT) REQUIREMENTS**

While CMS would maintain its recommendation that ECs migrate to EHR technology certified to the 2015 Edition, the agency would allow continued use of EHR technology certified to the 2014 Edition in 2018. To incentivize use of 2015 CEHRT, CMS proposes a bonus of 10 percentage points in ACI for clinicians and groups that adopt and use 2015 CEHRT throughout a 90-day reporting period in 2018.
MIPS CATEGORY: QUALITY

CMS would continue to require ECs and groups to report six quality measures, including one outcome or high priority measure, and would evaluate each measure against a benchmark to determine a score of up to 10 points per measure. CMS proposes to continue requiring reporting on at least 50% of applicable patient encounters for measures submitted using qualified clinical data registries (QCDRs), qualified registries, EHRs or claims. Each measure that meets the 50% data completeness threshold would continue to score a minimum of three points. However, measures that fall below the 50% threshold would receive one point, a reduction from the current three-point floor for submitting one measure, one time. Small practices, however, would continue to receive at least three points for quality measures regardless of whether the data completeness threshold is met.

CMS proposes to cap a subset of six “topped out” measures listed in Table 21 at six points. Through future rulemaking, the agency would remove measures from the MIPS measures list after being topped out for three consecutive years. CMS considers a measure topped out if performance is so high and unvarying that meaningful distinctions and improvement in performance cannot be made. Based on 2015 PQRS data, CMS identified approximately 45% of quality measures as topped out, including 70% of claims measures, 10% of EHR measures, and 45% of registry and QCDR measures.

CMS proposes to add up to 10 percentage points to an EC’s or group’s quality score based on improvement from the prior year to the current year. Finally, to account for mid-year changes to measure specifications due to ICD-10 updates, CMS proposes to assess performance on significantly impacted measures based on the first nine months of the 12-month performance period. CMS would consider a measure significantly impacted if 10% or more of the diagnosis codes (i.e., ICD-10 codes) cited in a measure specification change, among other factors.

MIPS CATEGORY: IMPROVEMENT ACTIVITIES

This category would remain largely the same in 2018. CMS would continue scoring improvement activities out of 40 points, which clinicians could achieve by reporting or attesting to up to four activities via a “yes” designation. The agency proposes to add to and update the inventory of activities that qualify for credit. CMS proposes modifications to the improvement activities study, including expanding the sample size from 42 to 118 groups and changing the name to “CMS study on burdens associated with reporting quality measures.” The study purpose would not change, and participants would continue to earn 100% in the category.

As required by statute, CMS will continue to give certified patient-centered medical homes (PCMHs) or comparable specialty medical homes the maximum improvement activities score. The agency proposes to expand the definition of a PCMH by including CPC+ participants and control groups and to clarify that a “recognized” PCMH is equivalent to a “certified” PCMH. CMS also plans to require at least 50% of practice sites within one tax identification number (TIN) be recognized as a PCMH for the TIN to receive full credit toward the category, which is an increase from the current requirement that only one practice site needs to qualify.

MIPS CATEGORY: ACI

ACI would continue to require ECs and groups to report four, mandatory base measures (i.e., security risk analysis, electronic access, e-prescribing and health information exchange) to avoid a
score of zero and receive a 50% ACI base score. ECs and groups would continue to select among seven optional performance measures to earn an additional 50% ACI performance score. The agency proposes a new exclusion for the e-prescribing and health information exchange measures. To qualify, ECs must write fewer than 100 permissible prescriptions or transfer a patient to another setting or refer a patient fewer than 100 times during the performance period.

CMS also proposes additional improvement activities that would qualify for an ACI bonus, including consultation of appropriate use criteria (AUC) through a clinical decision support mechanism (CDSM) for all advanced diagnostic imaging service orders. Clinicians who report to an immunization registry would receive 10%, in the performance score. If a clinician cannot report to an immunization registry, they may earn 5 percentage points in the performance score for each public health agency to which they report, up to 10%.

CMS proposes to add a new, retroactive exception for ECs whose EHR was decertified. There would also be a hardship exception for small practices (defined as 15 or fewer clinicians) that face barriers to meeting ACI. For these practices, the ACI component of MIPS would be reweighted to zero, and 25% category weight would be reallocated to quality. CMS also proposes to extend the deadline to submit the hardship exception application for 2017 and future years from July 1 to Dec. 31 of the performance year. In addition, ECs who furnish 75% of services in ambulatory surgical centers (POS 24) would have their ACI score automatically reweighted to zero and would not need to apply for a hardship exception.

**MIPS Category: Cost**

Cost measures would remain weighted at 0% in 2018 and continue to be excluded from the final MIPS score. Although the measures do not count, CMS would continue to evaluate cost data and include the results in MIPS feedback reports. CMS proposes to calculate improvement to cost scores from the prior year, but, in a nod to the complexity of this program, the agency would use a different methodology than the one proposed for measuring quality score improvement.

**Facility-Based Measurement**

CMS proposes a voluntary, facility-based measurement option for clinicians who perform at least 75% of their services in the hospital inpatient or emergency room setting and groups with 75% or more such clinicians. The agency would calculate the quality and cost scores for interested facility-based clinicians and groups using a hospital’s performance in the Medicare Hospital Value-Based Purchasing (VBP) program. CMS proposes to notify facility-based clinicians and groups of their attributed hospital’s VBP performance prior to the deadline to elect facility-based measurement.

**Virtual Groups**

CMS proposes rules for forming a “virtual group” comprised of multiple solo practitioners and group practices with 10 or fewer ECs practicing under different TINs. Virtual groups would participate collectively in MIPS and be scored jointly. If finalized, interested clinicians and groups could request an eligibility determination prior to forming a virtual group to ensure they do not exceed 10 ECs and are not excluded under the low volume threshold. Virtual groups would be required to notify CMS of their formation by Dec. 1 of the year prior to the performance period and sign a written agreement. Group reporting policies would generally apply to virtual groups, which
would be required to aggregate each participant’s quality, improvement activity and ACI data prior to submission to CMS. The agency projects 16 virtual groups will form for 2018.

**MIPS SCORING STANDARD FOR APMs**

Either because an APM does not qualify as an Advanced APM or because a particular entity does not meet qualified participant (QP) thresholds of participation, ECs and groups may both participate in an APM and be subject to MIPS in 2018. For those ECs and groups, CMS proposes to keep the weight of the cost component neutral and count quality as 50% of the final score, ACI as 30% and improvement activities as 20%. To accommodate APMs that do not submit quality data via CMS Web Interface, CMS proposes to calculate the quality score using data submitted to CMS through the APM and using the APM’s benchmarks, when available. In addition to existing participation “snapshots” taken on March 31, June 30, and Aug. 31, CMS would evaluate participation lists on Dec. 31 of the performance period for certain APMs to count participants who join an APM in the second half of the calendar year.

**Proposed 2018 changes: Advanced Alternative Payment Models (APMs)**

**MEDICARE OPTION**

CMS anticipates the number of QPs in Advanced APMs would double from 2017 to 2018 given the new MSSP Track 1+ and reopening of applications for the Next Generation and CPC+ programs. However, CMS proposes no additional Advanced APMs. The agency would maintain the revenue-based “nominal amount” (previously “nominal risk”) standard for Advanced APMs at 8% of revenue for 2019-20 and would establish a matching 8% revenue-based standard for Other Payer Advanced APMs. The agency is seeking input on whether it should establish a separate, lower standard specifically for small and rural practices. The nominal amount standard for Medical Home Models (MHMs) would similarly increase gradually, remaining at 2% in 2018 and increasing by 1% each year before capping at 5% in 2021. CPC+ participants who started in 2017 would be exempted from the 50-clinician cap for MHMs, but the cap would apply to future participants.

In general, for Advanced APMs that start or end during the performance period, CMS proposes to count only the dates APM Entities actively participated in the model toward QP thresholds, so long as participation lasted 60 or more continuous days. Track 1 of the Comprehensive Care for Joint Replacement Model and clinicians participating in multiple Advanced APMs or All-Payer APMs would be exempt from this policy. The proposed rule also clarifies that if a clinician achieves QP status through participation in multiple Advanced APMs and one of those APM Entities terminates prior to Aug. 31, that clinician would lose QP status.

**ALL-PAYER OPTION**

Starting in 2019, clinicians may become QPs through the All-Payer Option, which considers participation in non-Medicare Advanced APMs. CMS proposes to establish two distinct, voluntary “Other Payer Advanced APM Determination Processes” in which payers, followed by individual APM Entities and clinicians, may annually request determinations for payment arrangements to be considered for a given performance year. Submitters would be notified “as soon as practicable” whether their payment arrangement was accepted, and a comprehensive list would be publicly posted to the CMS website following each round. All determinations would be considered final.
In a departure from a previously finalized policy, CMS proposes to make All-Payer QP determinations based on two overlapping intervals (Jan. 1 - March 31 and Jan. 1 - June 30), during at least one of which the APM Entity must satisfy QP thresholds. The agency proposes to make All-Payer QP determinations exclusively at the clinician level. However, APM Entities would be able to submit information to CMS on behalf of participating clinicians. All information and data relevant to QP determinations would be due to CMS by Dec. 1 of the performance period.

**Physician-Focused Payment Models (PFPMs)**

CMS seeks input about broadening the definition of PFPMs to include payment arrangements that involve Medicaid or the Children’s Health Insurance Program as a qualifying federal payer, as opposed to exclusively Medicare. PFPMs may be considered Advanced APMs, but this is not guaranteed.

**2018 Medicare physician fee schedule proposed rule**

**Request for information on CMS flexibilities and efficiencies**

The agency seeks input regarding opportunities to reduce regulatory burdens on physician practices and make the delivery system less bureaucratic and complex. MGMA has long championed administrative simplification and regulatory relief and strongly supports this Administration’s efforts to mitigate or eliminate obsolete and burdensome rules. We will submit detailed recommendations to significantly decrease unnecessary paperwork and improve the quality and efficiency of healthcare delivery in this country.

**Physician payment update and misvalued codes target**

CMS estimates the 2018 Medicare PFS conversion factor will be $35.9903, which includes a 0.5% update as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The conversion factor calculation, included below, also factors in adjustments due to budget neutrality and the misvalued code target recapture amount. Due to laws passed in recent years, physician payment is affected by whether CMS meets annual targets for reductions in PFS expenditures by adjusting the RVUs of codes identified as misvalued. For 2018, the annual target is 0.5%. CMS estimates the net readjustment to misvalued codes in 2018 would be 0.31%, falling below the 2018 annual target and triggering a requirement to lower the conversion factor by the difference between the net adjustment and the target. If finalized, the conversion factor would be reduced by 0.19%.

**Table 38: Calculation of the Proposed CY 2017 PFS Conversion Factor**

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<thead>
<tr>
<th>Conversion Factor in effect in CY 2017</th>
<th>35.8887</th>
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</thead>
<tbody>
<tr>
<td>Update Factor</td>
<td>0.50 percent (1.0050)</td>
</tr>
<tr>
<td>CY 2017 RVU Budget Neutrality Adjustment</td>
<td>-0.03 percent (0.9997)</td>
</tr>
<tr>
<td>CY 2017 Target Recapture Amount</td>
<td>-0.19 percent (0.9981)</td>
</tr>
<tr>
<td>CY 2018 Conversion Factor</td>
<td><strong>35.9903</strong></td>
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</tbody>
</table>

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 6% for diagnostic testing facilities. In contrast, other proposals would result in overall payment increases of 3% for
clinical social workers and 2% for clinical psychologists. Table 40 displays the estimated impact on total allowed charges by specialty resulting from the proposed payment changes.

**MEDICARE TELEHEALTH SERVICES AND REMOTE PATIENT MONITORING**

CMS proposes to make the following additions to the 2018 approved list of Medicare telehealth services:

- Counseling visit to discuss need for lung cancer screening using Medicare G-code G0296.
- Psychotherapy for crisis CPT codes 90839 and 90840.
- Interactive complexity CPT code 90785.
- Health risk assessment CPT codes 96160 and 96161.
- Care planning for chronic care management services using Medicare G-code G0506.

The agency proposes to eliminate the requirement for the distant site provider to report the GT modifier on claims, believing it is superfluous since distant site providers are now using a place of service code (POS 02) to indicate telehealth requirements have been met. Institutional providers would continue to use the GT modifier, and participants in federal telemedicine demonstration programs in Alaska or Hawaii would continue to use the GQ modifier.

CMS is soliciting comment on how to further expand access to telehealth within their statutory authority and whether to make separate payment for remote patient monitoring.

**TRANSITION FROM TRADITIONAL X-RAY IMAGING TO DIGITAL RADIOGRAPHY**

The Consolidated Appropriations Act of 2016 mandates a 7% payment reduction to the technical component (TC) of x-rays taken using computed radiography during years 2018 to 2022 and a 10% reduction thereafter. Beginning on Jan. 1, 2018, CMS proposes to require a new modifier on claims for the TC of computed radiography x-ray services, including when the service is billed globally. Statutorily mandated payment cuts of 20% and use of a modifier for film x-rays began in 2017.

**PAYMENT RATES FOR NON-EXCEPTED, OFF-CAMPUS PROVIDER-BASED DEPARTMENTS**

Beginning in 2017, CMS pays for certain items and services furnished in off-campus, provider-based departments that did not bill Medicare prior to Nov. 2, 2015 or are otherwise not exempted under the PFS rather than the Outpatient Prospective Payment System (OPPS), as required by statute. Currently, CMS pays for these services under the PFS at a rate that is approximately 50% of the OPPS rate for the same code. The agency proposes to further reduce the payment rate for these services from 50% to 25%. Physicians would continue to be reimbursed for the professional component of the service at the facility rate under the PFS. CMS believes this proposal would better align overall payment rates for services furnished in off-campus hospital departments with services furnished in physician practices and paid at the non-facility PFS rate.

**EVALUATION AND MANAGEMENT (E/M) GUIDELINES**

CMS believes the E/M guidelines are outdated and proposes a multi-year effort to update the guidelines, reduce administrative burden on physician practices and better align E/M coding and documentation with the current practice of medicine. The agency seeks input regarding reducing or eliminating guidelines for documenting history and medical exam and placing greater importance on medical decision making and time to determine the appropriate level of E/M visit code.
PAYMENT FOR CARE COORDINATION SERVICES AT RURAL HEALTH CENTERS (RHCs) AND FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

CMS proposes to adopt two new G codes to reimburse RHCs and FQHCs for non-face-to-face general and psychiatric collaborative care management. Payment for these services would be in addition to the payment for an RHC or FQHC visit.

SOLICITATION OF COMMENT ON MEDICARE CLINICAL LABORATORY FEE SCHEDULE (CLFS) DATA COLLECTION

The Protecting Access to Medicare Act (PAMA) requires CMS to revalue the CLFS and establish reimbursement rates at the median private payer price for applicable laboratory services. To determinate new rates, CMS requires applicable laboratories to collect and report private payer rate and volume data every three years. The first data collection period was Jan. 1 through June 30, 2016, and the first reporting period was Jan. 1 through March 31, 2017 (with the ability to submit data until May 30). CMS intends to use this data to calculate 2018 CLFS payment rates.

CMS is soliciting comment on applicable laboratories’ initial experiences with data collection, reporting and other compliance requirements to inform potential improvements for future periods.

PAYMENT FOR BIOSIMILAR BIOLOGICAL PRODUCTS

In the 2016 PFS, CMS clarified that it will pay for biosimilar biological products based on the average sales price of all National Drug Codes assigned to that product plus 6%. The agency is seeking comment on this policy, particularly in the form of market analysis or research into the current economics of the biosimilar marketplace and data that demonstrates how specific reimbursement codes could impact the market.

APPROPRIATE USE CRITERIA (AUC) FOR ADVANCED DIAGNOSTIC IMAGING SERVICES

Under PAMA, CMS must establish a program that denies payment for advanced diagnostic imaging services unless the ordering professional adheres to AUC using a qualified CDSM. Congress intended the program to begin in 2017; however, due to complexity and pressure from stakeholder groups such as MGMA, CMS proposes to delay the start date until Jan. 1, 2019. This first year would be an educational and testing year, where professionals must consult AUC using a qualified CDSM when ordering applicable imaging services and furnishing professionals must report consultation on the Medicare claim, but claims denial would not begin until 2020. Despite any delay, CMS expects a voluntary reporting period to begin in July 2018 and would incentivize early adoption by providing improvement activities credit under MIPS.

To implement AUC reporting requirements, CMS proposes claims processing instructions. Namely, the agency plans to establish a set of G-codes to describe which qualified CDSM was used by the ordering professional, as well as a series of modifiers to identify adherence to AUC or exceptions, including for professionals who qualify for a significant hardship. CMS seeks comment on how to include this information on claim forms.

The agency proposes to modify its policy on hardship exceptions for ordering professionals to align with the ACI component of MIPS. CMS proposes to exempt from AUC any professional who is not
required to report for ACI in MIPS, but would continue to maintain a separate hardship process under the AUC program for those who report for ACI.

**PQRS and Meaningful Use Reporting Requirements**

Under previously finalized policies for the 2016 PQRS reporting year, clinicians were generally required to report nine quality measures, including one cross-cutting measure, across three national quality strategy (NQS) domains to avoid a 2% penalty in 2018. Following calls from MGMA to reduce the reporting burden and align past requirements with MIPS, CMS proposes to retroactively reduce PQRS and EHR Incentive Program (Meaningful Use) reporting requirements to six measures with no additional NQS or cross-cutting measure stipulations. The agency would also relax the previously-mandated requirement that groups of 100 or more eligible professionals (EPs) administer the CAHPS for PQRS survey. Instead, the agency proposes to award PQRS credit to groups that did administer the survey, but would not penalize groups that did not. These proposed changes would not impact the qualified registry measures groups option and would also not apply to the 2015 reporting year, with one exception for groups participating in the Accountable Care Organization (ACO) Secondary Reporting Period if their ACO failed to report on their behalf. CMS notes that if less than six measures were reported, the measure application validity process would still apply. The proposed modified requirements are summarized in Tables 20 and 21 for individual and group reporters, respectively.

**Value-Based Payment Modifier (VM)**

In response to MGMA advocacy efforts to reduce penalties for the now retired quality reporting programs, CMS proposes to reduce the overall scope and size of VM penalties in 2018 based on 2016 performance. First, for practices who fell short of PQRS criteria, the agency would cut the automatic VM penalty in half, from 4% to 2% for groups of 10 or more EPs, and from 2% to 1% for group practices of nine or fewer EPs or those consisting of only non-physician EPs. Second, CMS would hold harmless any practices who fully satisfied the modified PQRS reporting requirements (e.g., six measures). The VM is budget neutral, and therefore, if finalized as proposed, the new 2018 payment policy would result in fewer or less significant payment adjustments.

**Physician Compare**

Due to proposed VM policy changes, CMS proposes not to move forward with reporting practice-specific 2016 VM performance and payment adjustment information, including whether a clinician or group was eligible to but did not report PQRS data, to the Physician Compare website as previously finalized. However, the agency would proceed with publishing public files containing non-practice-specific VM data and publicly reporting 2016 PQRS quality data.

**MSSP**

To reduce administrative burden, CMS proposes to eliminate some of the up-front documentation required during the MSSP initial application and skilled nursing facility (SNF) 3-day waiver application processes, including demonstration of how an ACO meets leadership/management and care processes/patient-centeredness criteria.

Regarding beneficiary assignment, CMS proposes to add several new complex chronic care management codes (99847, 99489, and G0506) and behavioral health service codes (G0502, G0503, G0504, and G0507) to the list of primary care services. The agency would also
automatically count all services reported by RHCs and FQHCs as primary care services furnished by primary care physicians and would no longer require burdensome attestations stating such. These changes would both take effect in 2019.

In the interest of stabilizing financial calculations for benchmarks and performance year expenditures, starting in 2018, CMS would no longer count interim, non-claims based payments made under a demonstration, pilot or time-limited program that are subject to reconciliation at a later date. The agency would also revise its policy for handling TINs who violate exclusivity requirements. TINs would be allowed to remain on multiple participation lists for the remainder of the performance year in which the violation is discovered; however, all services furnished by that TIN would be excluded from beneficiary assignment for any ACO for that year. ACOs would then be required to correct any overlaps for the subsequent performance year and may be subject to additional compliance actions.

The 2018 MIPS/APMs proposed rule included several changes to the Web Interface measure set that would impact MSSP reporters. In general, CMS also proposes to modify current regulations to afford the agency more flexibility in designating measures as pay-for-reporting outside of the formal rulemaking process.

CMS proposed two major modifications to the quality audit process. The agency would lower the minimum match rate that triggers an audit from 90% to 80% (the median match rate in 2016) and make changes to how audits impact an ACO’s final quality score. Under the proposal, an ACO’s quality score would be reduced by 1% for every 1% difference between an ACO’s match rate and the proposed 80% standard threshold, which the agency would also seek to increase over time.

**MACRA patient relationship categories**

In MACRA, Congress directed CMS to develop patient relationship categories to more accurately attribute patients for purposes of holding clinicians responsible for the cost of care in MIPS. CMS proposes to instruct clinicians to include new HCPCS modifiers on claims to indicate the physician’s relationship with the patient, but it would not be a condition of payment.

<table>
<thead>
<tr>
<th>Proposed HCPCS modifier</th>
<th>Patient relationship category</th>
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<tbody>
<tr>
<td>X1</td>
<td>Continuous/broad services</td>
</tr>
<tr>
<td>X2</td>
<td>Continuous/focused services</td>
</tr>
<tr>
<td>X3</td>
<td>Episodic/broad services</td>
</tr>
<tr>
<td>X4</td>
<td>Episodic/focused services</td>
</tr>
<tr>
<td>X5</td>
<td>Only as ordered by another clinician</td>
</tr>
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Claims would be paid regardless of whether and how the modifiers are included, and CMS would educate clinicians on proper use of these modifiers. Additionally, CMS would not consider patient relationship information in MIPS.

**MEDICARE DIABETES PREVENTION PROGRAM (DPP)**

CMS expanded the DPP, a model aimed at preventing type 2 diabetes in prediabetic individuals, and finalized several components of the program in the 2017 PFS final rule. In this rule, CMS proposes refinements and additional model details, including a maximum payment rate of $810 over
three years for furnishing educational sessions designed to change behavior for weight control and on-going maintenance classes, as well as demonstrating sustained weight loss by the beneficiary. CMS also proposes a two-year time limit on Medicare coverage of ongoing maintenance sessions. The agency would delay the start of the model until April 1, 2018. Finally, CMS seeks input regarding a separate demonstration project testing a virtual DPP delivery system.

MGMA Government Affairs staff will continue to review these proposed regulations, and members who have questions should contact us at 202-293-3450 or govaff@mgma.org.