



## **In-Depth Analysis of the 2017 MPFS Proposed Rule**

On July 15, 2016, the calendar year (CY) [2017 Medicare Physician Fee Schedule \(PFS\) Proposed Rule](#) was published in the Federal Register. AGA, ACG and ASGE have developed this summary of key provisions in the proposed rule to help GI practices prepare for the payment and policy changes that may take effect Jan. 1, 2017.

### **Major Provisions in the CY 2017 Medicare Physician Fee Schedule Proposed Rule Payment Policy**

- [Physician Payment Update](#)
- [Proposed Valuation of New Moderate Sedation Codes](#)
- [Proposed Valuation of Services Where Moderate Sedation is an Inherent Part of the Procedures](#)
- [Anesthesia Services Furnished in Conjunction with Upper and Lower GI Endoscopy Procedures](#)
- [Misvalued Codes Target](#)
- [GI Tract Imaging Procedures](#)
- [Technical Corrections to Direct Practice Expense \(PE\) Inputs for Ileoscopy Codes](#)
- [Esophagogastric Fundoplasty, Transoral Approach](#)
- [Liver Elastography](#)
- [Non Face-to-Face Prolonged Services — Evaluation and Management Codes](#)
- [Appropriate Use Criteria for Advanced Diagnostic Imaging Services](#)
- [Improving Payment Accuracy for Care Management and Patient-Centered Services](#)
- [Medicare Advantage Provider Enrollment](#)
- [Medicare Shared Savings Program and Accountable Care Organization \(ACO\) Quality Reporting](#)
- [Value-Based Payment Modifier and Physician Feedback Program](#)

### **Physician Payment Update**

The **CY 2017 PFS conversion factor is estimated to be \$35.7751**, which reflects:

- Budget neutrality adjustment.
- A .5 percent update adjustment factor specified for CY 2017 by the Medicare Access and CHIP Reauthorization Act (MACRA).
- Adjustment due to the non-budget neutral 5 percent Multiple Procedure Payment Reduction (MPPR) for the professional component of imaging services (Table 1).

**Table 1: Calculation of the Proposed CY 2017 PFS Conversion Factor**

<b>Conversion Factor in effect in CY 2016</b>		<b>\$35.8043</b>
Update adjustment factor	0.50 percent (1.0050)	
CY 2017 Relative Value Unit (RVU) budget neutrality adjustment	-0.51 percent (0.9949)	
CY 2017 target recapture amount	0 percent (1.0000)	
CY 2017 imaging MPPR adjustment	-0.07 percent (0.9993)	
<b>CY 2017 Conversion Factor</b>		<b>\$35.7751</b>

CMS estimates the 2017 average impact on total allowed charges for gastroenterology is -1 percent (Table 2).

**Table 2: CY 2017 PFS Estimated Impact on Total Allowed Charges**

<b>Specialty</b>	<b>Allowed Charges (mil)</b>	<b>Impact of Work RVU Changes</b>	<b>Impact of PE RVU Changes</b>	<b>Impact of MP RVU Changes</b>	<b>Combined Impact</b>
Gastroenterology	\$1,744	0%	0%	0%	-1%

### **Proposed Valuation of New Moderate Sedation Codes**

(Codes 991X1, 991X2, 991X3, 991X4, 991X5, 991X6 AND HCPCS GMMM1)

In the CY 2015 PFS proposed rule, CMS noted that for endoscopic procedures, it appeared that anesthesia services were increasingly being separately reported, meaning that resource costs associated with sedation were no longer being incurred by the practitioner reporting the procedure. Subsequently, in the CY 2016 PFS proposed rule, CMS sought recommendations on approaches to address the appropriate valuation of moderate sedation related to the approximately 400 diagnostic and therapeutic procedures, including the majority of GI endoscopy procedures, for which the American Medical Association (AMA) CPT Editorial Panel had determined that moderate sedation was an inherent part of furnishing the service.

To address this issue, the CPT Editorial Panel created separate CPT codes for reporting of moderate sedation services to be published in CPT 2017. They are listed in the proposed rule as 991X1-991X6, but their permanent 5-digit CPT codes will be published in the CPT 2017 book this fall. The codes were surveyed by specialties with procedures involving moderate sedation, including the GI societies, during the summer in 2015, the data were presented to the RUC in October 2015, and the RUC provided CMS with its relative value recommendations.

The survey data for 991X2 (*Moderate sedation provided by the same physician...; initial 15 minutes of intraservice time, patient age 5 years or older*) showed a significant bimodal distribution between procedural services furnished by gastroenterologists and those services furnished by other specialties. Given the significant volume of moderate sedation furnished by GI practitioners and the significant difference in Relative Value Units (RVUs) reported in the survey data, **CMS has proposed a new Healthcare Common Procedure Coding System (HCPCS) code, GMMM1, for GI endoscopy-specific moderate sedation.**

Based on the GI societies' survey data, CMS proposes 0.10 work RVUs (wRVUs) for GMMM1 for all endoscopic procedures where moderate sedation is inherent to the procedure, except for biliary endoscopy procedures (43260-43265, 43274-43278) where CMS proposes to require use of code 991X2. CMS accepted the RUC recommended wRVU of 0.25 for all other procedures reported with 991X2. The proposed values for all moderate sedation codes are listed in Table 3 below.

**Table 3: Moderate Sedation Codes and Physician Work RVUs**

Code	Descriptor	Work RVU
<b>Moderate sedation provided by the same physician</b>		
GMMM1	Moderate sedation services provided by <u>the same physician</u> or other qualified health-care professional <u>performing a gastrointestinal endoscopic service (excluding biliary procedures)</u> that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; <u>initial 15 minutes of intra-service time, patient age 5 years or older.</u>	0.10
991X1	Moderate sedation services provided by <u>the same physician</u> or other qualified health-care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; <u>initial 15 minutes of intra-service time, patient younger than 5 years of age.</u>	0.50
991X2	Moderate sedation services provided by <u>the same physician</u> or other qualified health-care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; <u>initial 15 minutes of intra-service time, patient age 5 years or older</u>	0.25
+991X5*	Moderate sedation services provided by <u>the same physician</u> or other qualified health-care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; <u>each additional 15 minutes of intra- service time (List separately in addition to code for primary service).</u>	0.00
<b>Moderate sedation provided by a different physician</b>		
991X3	Moderate sedation services provided by a physician or other qualified health-care professional <u>other than the physician</u> or other qualified health-care professional performing the diagnostic or therapeutic service that the sedation supports; <u>initial 15 minutes of intra-service time, patient younger than 5 years of age.</u>	1.90
991X4	Moderate sedation services provided by a physician or other qualified health-care professional <u>other than the physician</u> or other qualified health-care professional performing the diagnostic or therapeutic service that the sedation supports; <u>initial 15 minutes of intra-service time, patient age 5 years or older.</u>	1.84
+991X6*	Moderate sedation services provided by a physician or other qualified health-care professional <u>other than the physician</u> or other qualified health-care professional performing the diagnostic or therapeutic service that the sedation supports; <u>each additional 15 minutes intra-service time (List separately in addition to code for primary service).</u>	0 . 0 0

\* Add-on codes 991X5 and 991X6 contain practice expense (PE) inputs only (i.e., equipment, supplies and staff associated with the provision of moderate sedation).

### **Proposed Valuation of Services Where Moderate Sedation is an Inherent Part of the Procedures**

CMS proposes to directly remove the relative value assigned to moderate sedation codes GMMM1 and 991X1-991X6 from the approximately 400 diagnostic and therapeutic procedures, including the majority of GI endoscopy procedures.

**There will be no financial impact to physician work for gastroenterologists who perform their own moderate sedation** as they will report two codes instead of one beginning January 2017 — the procedure code and the proposed moderate sedation code — to maintain the CY 2016 physician work value.

**Gastroenterologists who use anesthesia professionals will see the physician wRVUs of the majority of GI endoscopy procedures reduced by 0.10, with the exception of ERCP procedures (CPT 43260-43265, 43274-43278).** The 0.10 wRVU reduction is less onerous than the 0.25 RVUs recommended by the RUC for 991X2 and implemented for all other specialties' procedures. **CMS proposes ERCP procedures to be reported with 991X2, not GMMM1.**

**PE inputs associated with moderate sedation (i.e., equipment, supplies and staff time) will also be removed from the affected endoscopy codes.** The effect on PE RVUs is variable depending on the length of intra-service time of the procedure. The GI societies are reviewing the PE inputs proposed for the moderate sedation codes and will provide comments to CMS.

### **Anesthesia Services Furnished in Conjunction with Upper and Lower GI Endoscopy Procedures** (CPT 00740, 00810)

**CMS proposes to maintain the current five base units for anesthesia procedures in CY 2017 for upper and lower GI endoscopy procedures,** but continues to request public input on the value. In the CY 2016 PFS proposed rule, CMS noted that Medicare claims data indicate a separate anesthesia service is now reported more than 50 percent of the time that several types of colonoscopy procedures are reported. Given the significant change in the relative frequency with which anesthesia codes are reported with colonoscopy services, CMS believes the relative values of the anesthesia services should be reexamined. In response, the RUC reviewed codes 00740 and 00810 in January 2016. Due to concerns about the typical patient vignettes used in the surveys, the RUC recommended that the codes be resurveyed again using new vignettes and that CMS maintain the current values on an interim basis. The RUC will reevaluate the anesthesia codes and is expected to provide new recommendations to CMS in early 2017.

### **Misvalued Codes Target**

The statutorily mandated misvalued code target of 0.5 percent for CY 2017 will be met based on CMS' proposal that changes in code values would be measured in the target across three full years: the original value in the first year (CY 2015); the interim final value in the second year (CY 2016); and the finalized value in the third year (CY 2017). **By meeting the target, an overall reduction to PFS services will be avoided in CY 2017.**

## GI Tract Imaging (91110, 91111)

In the CY 2016 PFS Final Rule, CMS identified 103 codes as potentially misvalued under the High Expenditure by Specialty Screen, including CPT code 91110 (*Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with interpretation and report*). The GI societies surveyed code 91110 and related code 91111 (*Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus with interpretation and report*), and presented recommendations to the RUC in January 2016. CMS accepted the RUC recommendations for physician work (Table 4) and PE inputs.

**Table 4: CMS Proposed Work RVUs for GI Tract Imaging Procedures**

HCCPS	Descriptor	Current work RVU	RUC work RVU	CMS work RVU	CMS time refinement
91110	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with interpretation and report	3.64	2.49	2.49	No
91111	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus with interpretation and report	1.00	1.00	1.00	No

## Technical Corrections to Direct PE Inputs for Ileoscopy (Codes 44380-44382)

CMS proposes to correct inconsistencies in PE identified by the GI societies in our comments on the 2016 PFS Final Rule with comment period. **CMS will add the Gomco suction machine (EQ235) to the proposed direct PE input database for ileoscopy** CPT code 44380 at a time of 29 minutes, for CPT code 44381 at a time of 39 minutes, and to CPT code 44382 at a time of 34 minutes.

## Esophagogastric Fundoplasty, Transoral Approach (Code 43210)

For CY 2016, the CPT Editorial Panel established CPT code 43210 to describe trans-oral esophagogastric fundoplasty. The RUC recommended a work RVU of 9.00 for CPT code 43210. CMS established an interim final work RVU of 7.75, which corresponds to the 25th percentile survey result. The GI societies urged CMS to accept the RUC-recommended work RVU of 9.00 for CPT code 43210 and requested refinement panel consideration for this service. CMS referred the code to the CY 2016 multispecialty refinement panel for further review, which recommended that CMS accept the RUC-recommended value of 9.00 work RVUs.

**For CY 2017, CMS proposes maintaining 7.75 wRVUs for 43210**, as the agency continues to believe that the 25th percentile of the survey most accurately reflects the relative resource costs associated with CPT code 43210. The GI societies disagree with the recommendation and will provide comments to CMS.

## **Liver Elastography** (Code 91200)

For CY 2016, CMS accepted as interim final the RUC recommendation of 0.27 RVUs for liver elastography code 91200 and applied the standard 50 percent utilization rate for the FibroScan equipment. The GI societies recommended a 25 percent utilization rate which corresponds to the average number of procedures. **For 2017, CMS proposes to maintain the use of 50 percent utilization and to correct the work time to 16 minutes for consistency with the RUC's recommended time.**

## **Non Face-to-Face Prolonged Services Evaluation and Management Codes**

Historically, CMS has considered codes 99358 (*Prolonged evaluation and management service before and/or after direct patient care, first hour*) and 99359 (*Prolonged evaluation and management service before and/or after direct patient care, each additional 30 minutes (List separately in addition to code for prolonged service)*) to be bundled under the PFS. In the proposed rule, CMS agrees that these codes would provide a means to recognize the additional resource costs of physicians and other practitioners when they spend an extraordinary amount of time outside the in-person office visit caring for the individual needs of their patients. These non-face-to-face prolonged service codes are broadly described (although they include only time spent personally by the physician or other billing practitioner) and have a relatively high time threshold (the time counted must be beyond the usual service time for the primary or companion E/M code that is also billed).

**Beginning in CY 2017, CMS proposes to recognize CPT codes 99358 and 99359 for separate payment under the PFS, noting that time could not be counted more than once toward the provision of CPT codes 99358 or 99359 and any other PFS service.**

## **Appropriate Use Criteria for Advanced Diagnostic Imaging Services**

As required by Congress, CMS must establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. CMS is proposing an implementation date of Jan. 1, 2018 for this program. To be paid by Medicare for advanced diagnostic imaging services (defined to include magnetic resonance, computed tomography, nuclear medicine and positron emission tomography imaging services) under the PFS, Outpatient Prospective Payment System or Ambulatory Surgery Center Payment System, furnishing professionals and entities (including hospitals) must certify that professionals ordering advanced diagnostic imaging services consulted AUC applicable to the imaging modality using a clinical decision support mechanism (CDSM). CMS proposes to define a CDSM as, "an interactive, electronic tool for use by clinicians that communicates AUC information to the user and assists them in making the most appropriate treatment decision for a patient's specific clinical condition." In the proposed rule, CMS proposes CDSM requirements, as well as priority clinical areas upon which outlier ordering professionals will be identified. **Abdominal pain is one of eight priority clinical areas identified by CMS for this program.**

## **Improving Payment Accuracy for Care Management, and Patient-Centered Services**

In recent years, CMS created new codes that separately pay for chronic care management and transitional care management services, and solicited public comment on additional policies the



agency should pursue. CMS proposed a number of coding and payment changes to better identify care management and cognitive services:

- Make separate payments for certain existing CPT codes describing non-face-to-face prolonged evaluation and management services.
- Revalue existing CPT codes describing face-to-face prolonged services.
- Make separate payments using new codes to describe the comprehensive assessment and care planning for patients with cognitive impairment (e.g., dementia).
- Make separate payments for codes describing chronic care management for patients with greater complexity.
- Make several changes to reduce administrative burden associated with the chronic care management codes to remove potential barriers to furnishing and billing for these important services.

### **Medicare Advantage Provider Enrollment**

**CMS proposes to require providers or suppliers that furnish health-care items or services to a Medicare enrollee who receives Medicare benefits through a Medicare Advantage (MA) organization to be enrolled in Medicare and be in an approved status.** CMS believes the proposal will create consistency with the provider and supplier enrollment requirements for all other Medicare (Part A, Part B, and Part D) programs and assist CMS' efforts to prevent fraud, waste and abuse, and to protect Medicare enrollees by carefully screening all providers and suppliers to ensure that they are qualified to furnish Medicare items and services. Out-of-network or non-contract providers and suppliers are not required to enroll in Medicare to meet the requirements of this proposed rule. **CMS proposes to make the provisions effective the first day of the next plan year that begins two years from the date of publication of the CY 2017 PFS final rule.**

### **Medicare Shared Savings Program (MSSP) and Accountable Care Organization (ACO) Quality Reporting**

CMS proposed several refinements to the MSSP rules. Proposed policies related to ACO quality reporting, including:

- Proposed changes to the quality measures used to assess ACO quality performance.
- Changes in the methodology used in CMS' quality validation audits and the way in which the results of these audits may affect an ACO's sharing rate.
- Various issues related to alignment with policies proposed in the MACRA rule establishing the new Quality Payment Program (QPP).
- Revisions related to the terminology used in quality assessment, such as "quality performance standard" and "minimum attainment level."

### **Changes to the Quality Measures Used in Establishing the Quality Performance Standard**

CMS proposes to add and replace existing quality measures to align the MSSP quality measure set with the measures recommended by the Core Quality Measures Collaborative and proposed for reporting through the CMS web interface under the QPP proposed rule. **None of the proposed changes impact GI-related quality measures.**

## **Changes in the Methodology Used to Validate ACO Quality Data Reporting**

CMS proposes the following changes:

- **Increase the number of records audited per measure** to achieve a high level of confidence that the true audit match rate is within five percentage points of the calculated result. Currently, under CMS' phased methodology, the total number of records reviewed for each ACO varies (40 to 150 records per audited ACO during the performance year 2014 audit). **CMS is not proposing a specific number of records at this time, but does not anticipate more than 50 records will be requested per audited measure.**
- **Conduct the quality validation audit in a single step rather than the current multi-phased process.** Under this more streamlined approach, CMS would review all submitted medical records and calculate the match rate. The education CMS currently provides to ACOs and **the opportunity for ACOs to explain the mismatches would now occur at the conclusion of the audit. There would not be an opportunity for ACOs to correct and resubmit data for any measure with a >10 percent mismatch**, because CMS has learned through experience that resubmission of CMS web Interface measure data after the close of the CMS web Interface is not feasible. **Instead, an ACO's quality score would be affected by an audit failure (see below).**
- **Assess the ACO's overall audit match rate across all measures, instead of assessing the ACO's audit mismatch rate at the measure level.** CMS believes that making this change is necessary to minimize the number of records that must be requested in order to achieve the desired level of statistical certainty described earlier.
- **Indicate that, if an ACO fails the audit (i.e., an overall audit match rate of < 90 percent), the ACO's overall quality score would be adjusted proportional to its audit performance.** Currently, if at the conclusion of the audit process, there is a discrepancy greater than 10 percent between the quality data reported and the medical records provided, the ACO will not be given credit for meeting the quality target for any measures for which this mismatch rate exists. The audit-adjusted quality score will be calculated by multiplying the ACO's overall quality score by the ACO's audit match rate.
- **ACOs with an audit match rate of less than 90 percent may be required to submit a corrective action plan.**

## **Technical Changes Related to Quality Reporting Requirements**

CMS proposes to take all measures into account when determining whether a compliance action should be taken against an ACO based on its quality performance in one or more domains.

## **Technical Change to Application of Flat Percentages for Quality Benchmarks**

CMS proposes to no longer apply the flat percentage policy to performance measures calculated as ratios, such as the ambulatory sensitive conditions admissions measures and the all-cause readmission measure.

## **Incorporation of Other Reporting Requirements Related to the PQRS**

CMS believes that when an ACO does not satisfactorily report for purposes of PQRS, it may be appropriate to accept and use data that is reported outside the ACO. For PQRS to be able to accept



and use data reported outside the ACO, however, CMS proposes to lift the prohibition on separate reporting for purposes of the 2017 and 2018 PQRS payment adjustment.

### **Alignment with the Quality Payment Program (QPP)**

The [QPP proposed rule](#) specifically addresses eligible clinicians (ECs) that participate in APMs and advanced APMs, such as the Shared Savings Program. In the 2017 PFS proposed rule, CMS addresses regulatory modifications to the Shared Savings Program rules that must be proposed in order to support and align with the QPP proposals and to indicate that certain current reporting requirements apply to ACOs and their ECs only through the 2016 performance year. In addition, CMS proposes to require ACOs, on behalf of the ECs who bill under the tax ID number (TIN) of an ACO participant, to report quality measures through the CMS web interface in order to satisfy the QPP quality performance category. To maintain flexibility for EPs to report quality performance category data separately from the ACO, CMS does not propose to include a provision that would restrict an EP from reporting outside the ACO.

### **Incorporating Beneficiary Preference into ACO Assignment**

CMS supports incorporating beneficiary attestation into the assignment of beneficiaries to ACOs participating in the Shared Savings Program, to supplement and enhance the current claims-based algorithm-driven methodology. Supplementing the claims-based assignment algorithm with beneficiary attestations could further assure that beneficiaries are assigned to ACOs based on their relationship with providers that they believe to be truly responsible for their overall care.

**CMS proposes to begin to incorporate beneficiary attestation into the assignment methodology for the Shared Savings Program, effective for assignment for the 2018 performance year.** CMS proposes to implement an automated approach under which it could determine which health-care provider a fee-for-service (FFS) beneficiary believes is responsible for coordinating their overall care (their “main doctor”) using information that is collected in an automated and standardized way directly from beneficiaries (through a system established by CMS, such as [MyMedicare.Gov](#)), rather than requiring individual ACOs, ACO participants or ACO professionals to directly obtain this information from beneficiaries annually and then communicate these beneficiary attestations to CMS.

Under this proposal, an eligible beneficiary would be assigned to an ACO based on the existing claims-based assignment process unless the beneficiary has designated a health-care provider as being responsible for their overall care. If an eligible beneficiary has made such a designation, then the voluntary alignment would override the claims-based assignment process. **CMS proposes to make an automated attestation mechanism available for beneficiaries to voluntarily align with the provider or supplier that they believe is responsible for coordinating their overall care starting early in 2017**, making it possible for CMS to use beneficiary attestations for assigning beneficiaries to ACOs in all three tracks for the 2018 performance year.

### **Value-Based Payment Modifier (VM) and Physician Feedback Program**

CMS continues to support the need for an informal review mechanism for clinicians to identify any possible errors prior to application of the VM. Lessons learned from the volume and complexities of informal review issues that have been evaluated through the informal review process established in the CY 2013 PFS final rule and enhanced in subsequent rules, as well as unanticipated program issues, demonstrated a need to update the VM informal review policies.

The proposed revisions to the informal review process establish how the quality and cost composites under the VM would be affected for the CY 2017 and CY 2018 payment adjustment periods in the event that unanticipated program issues arise. The overall intent is to close out as many informal reviews as possible before the VM upward payment adjustment factor is calculated, to lend confidence to the adjustment factor, to provide finality for clinicians, and to minimize claims reprocessing. **Notably, CMS will hold clinicians harmless from a lower VM resulting from corrections.**

The following table delineates CMS' proposals for TINs moving from Category 2 (groups and solo practitioners subject to CY 2017 PQRS payment adjustment) to Category 1 (not subject to CY 2017 PQRS payment adjustment) as a result of an informal review, as well as TINs impacted by certain errors made by CMS or a third-party vendor.

	Scenario 1: TINS Moving from Category 2 to Category 1 as a result of PQRS or VM Informal Review Process		Scenario 2: Non-GPRO Category 1 TINs with Additional EPs Avoiding PQRS payment Adjustment as a result of PQRS Informal Review Process		Scenario 3: Category 1 TINs with Widespread Quality Data Issues		Scenario 4: Category 1 TINs with Widespread Claims Data Issues	
	Initial Composite	Revised Composite	Initial Composite	Revised Composite	Initial Composite	Revised Composite	Initial Composite	Revised Composite
Quality	N/A	Average	Low	Average	N/A	Average	Low	Average
	N/A	Average	Average	Average	N/A	Average	Average	Average
	N/A	Average	High	High	N/A	Average	High	High
Cost	Low	Low	Low	Low	Low	Low	Low	Low
	Average	Average	Average	Average	Average	Average	Average	Average
	High	Average	High	High	High	Average	High	Average

### **Participant TINs in Shared Savings Program ACOs that Do Not Complete Quality Reporting**

**CMS proposes to remove the prohibition on eligible providers who are part of a group or solo practitioner that participates in a Shared Savings Program ACO, for purposes of PQRS reporting for the CY 2017 and CY 2018 payment adjustments, to report outside the ACO.**

For the CY 2017 VM, for eligible providers who participate in an ACO that did not report on their behalf for purposes of PQRS, as required, CMS proposes a secondary reporting period which would coincide with the 2018 PQRS payment adjustment (i.e., Jan. 1, 2016, through Dec. 31, 2016). The affected eligible providers could report as a group or as an individual through registry, QCDR or EHR reporting options. The two-category approach used for groups and individual eligible providers outside of ACOs would be applied to this reporting. Those falling in Category 2 would be subject to a downward payment adjustment. Those falling in Category 1 would have their quality composite classified as "average quality," and, as finalized in the CY 2015 PFS final rule, the cost composite for these groups and individuals would be classified as "average cost."

It is important to note that **the affected groups and solo practitioners should expect to be initially classified as Category 2 and receive an automatic downward adjustment under the VM for services furnished in CY 2017 until CMS is able to process and evaluate the secondary data submission and update its payment system based on its determinations.** Since affected eligible providers will have missed the deadline for submitting an informal review request for the

2017 VM, CMS proposes the informal review submission period for affected eligible providers would occur during the 60 days following the release of the QRURs for the 2018 VM.

For the CY 2018 VM, when the ACO does not successfully report quality data on their behalf for purposes of PQRS as required, CMS proposes to use PQRS data reported by eligible providers as a group or as an individual through registry, QCDR or EHR reporting options. The two-category approach used for groups and individual eligible providers outside of ACOs would be applied to this reporting. Those falling in Category 2 would be subject to a downward payment adjustment. Those falling in Category 1 would have their quality composite classified as “average quality,” and as finalized in the CY 2015 PFS final rule, the cost composite for these groups and individuals would be classified as “average cost.”

### **More Information**

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