CMS proposes to expand the Medicare Diabetes Prevention Program model starting in 2018. This development marks the first time a preventive service model from the CMS Innovation Center and only the second time an Innovation Center model would be expanded into the Medicare program.

CMS also proposes to add several codes to the list of services eligible to be furnished via telehealth, including: Advance Care Planning (ACP) services and critical care consultations furnished via telehealth using new Medicare G-codes.

In addition CMS also proposes:

- Modifications to the Medicare ACO Shared Savings Program to update the quality measures set and align with the proposals for the Quality Payment Program (QPP) and the Core Quality Measures Collaborative recommendations, changes to take beneficiary preferences for ACO assignment into consideration, and changes that would improve beneficiary protections when ACOs are approved to use the Skilled Nursing Facility (SNF) 3-day waiver rule;
- Requiring health care providers and suppliers to be screened and enrolled in Medicare in order to contract with Medicare Advantage health plans;
- Increasing transparency of Medicare Advantage price data and medical loss ratio data; and
- Continuing to implement Appropriate Use Criteria for advanced diagnostic imaging services.

This regulation will be published in the July 15 *Federal Register* and comments are due to the agency by September 6. The AAFP is currently analyzing the regulation and will provide detailed comments to CMS.

Conversion Factor for 2017

To calculate the payment for each service, the relative value unit (RVU) components of the fee schedule (work, practice expense, and malpractice) are adjusted by geographic practice cost indices (GPCIs) to reflect the variations in the costs of furnishing the services. RVUs are converted to dollar amounts through the application of a conversion factor, which is calculated based on a statutory formula. The formula for calculating the Medicare fee schedule payment amount for a given service and fee schedule area can be expressed as:

Payment = [(RVU work x GPCI work) + (RVU practice expense x GPCI practice expense) + (RVU Malpractice x GPCI Malpractice)] x conversion factor.

For 2017, CMS estimates the conversion factor to be **$35.7751,** which is slightly lower than the 2016 conversion factor of $35.8043. Included at the end of the AAFP summary is CMS Table 41, which illustrates how CMS calculated the estimated 2017 conversion factor. Unlike in 2016, CMS did not need to apply an adjustment for a target recapture amount.

Also, included at the end of the AAFP summary is Table 43 (proposed rule estimated impact on total allowed charges by specialty). Family physicians, in aggregate and compared to other specialties, are projected to receive an estimated 3-percent increase in Medicare-allowed charges based on the provisions of the propose rule. This increase is the largest estimated update for a given specialty.

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

Background

The Medicare Payment Advisory Commission (MedPAC) commented to CMS that the fee schedule is an ill-suited payment mechanism for primary care and cognitive care generally. MedPAC recommended that Congress replace the expired Primary Care Incentive Payment (PCIP) with a capitated payment mechanism and expressed preference for codes like Chronic Care Management (CCM), which are