beneficiary-centered codes that do not pay for each distinct care coordination activity. Additionally, a number of modifications to the current CCM payment rules have been recommended to CMS in order to cover the cost of furnishing these services.

Proposed Changes

Of particular significance to primary care physicians, CMS proposes increased payments for several care management services; specifically, the regulation includes proposals that:

- Make separate payments for certain existing Current Procedural Terminology (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 using new codes to pay primary care practices that use interprofessional care management resources to treat patients with behavioral health conditions.
- Make separate payments using new codes to recognize the increased resource costs of furnishing visits to patients with mobility-related impairments.
- Make separate payments for codes describing CCM for patients with greater complexity.
- Make several changes to reduce administrative burden associated with the CCM codes to remove potential barriers to furnishing and billing for these important services.

Included at the end of this summary is an AAFP-created table that shows the national Medicare reimbursement amount unadjusted by geographic payment factors for these proposed services. Actual payment allowances for an individual physician will vary geographically and based on any other payment adjustments (PQRS, VM, etc.) that apply to the individual.

Identification and Review of Potentially Misvalued Services

Background

The *Affordable Care Act* requires CMS to periodically identify potentially misvalued services and to review and make appropriate adjustments to the relative values for those services. The *Achieving a Better Life Experience Act* set targets for adjustments to misvalued codes in the fee schedule for 2016, 2017, and 2018. The target was one percent for 2016 and 0.5 percent for each of 2017 and 2018. If the net reductions in misvalued codes in 2017 are less than 0.5 percent of the total revenue under the fee schedule, a reduction equal to the percentage difference between 0.5 percent and the percent of expenditures represented by misvalued codes reductions must be made to all fee schedule services.

Proposed Changes

CMS proposes misvalued code changes that achieve 0.51 percent in net expenditure reductions. If finalized, these changes meet the misvalued code target of 0.5 percent, thereby avoiding an overall reduction in Medicare payments.

Medicare Telehealth Services: End-Stage Renal Disease (ESRD) and Advanced Care Planning

Background

Several conditions must be met for Medicare to make payments for telehealth services under the fee schedule. The service must be on the list of Medicare telehealth services and meet all of these requirements; namely, that the service must be furnished:

- via an interactive telecommunications system.
- by a physician or other authorized practitioner.
- to an eligible telehealth individual.