Noting that a list of qualified CDSMs is not yet available and will not be available by January 1, 2017, CMS will not require ordering professionals to meet this requirement by that date. At the earliest, the first qualified CDSMs will be specified on June 30, 2017. CMS anticipates that providers may begin reporting as early as January 1, 2018.

CMS proposes three exceptions to the AUC consultation and reporting requirements:

- For an applicable imaging service ordered for an individual with an emergency medical condition;
- For applicable imaging services ordered for an inpatient and for which payment is made under Medicare Part A; and
- For an ordering professional who CMS determines, on a case-by-case basis and subject to annual renewal, that consultation with applicable AUC would result in a significant hardship, such as in the case of a professional practicing in a rural area without sufficient Internet access.

Medicare Shared Savings Program

Background

The Medicare Shared Savings Program is designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).

Proposed Changes

CMS proposes to make several policy changes to the Medicare Shared Savings Program regulations, including:

- Updates to ACO quality reporting, including:
    - Changes to the quality measure set to better align with the QPP proposed rule and recommendations from the Core Quality Measures Collaborative, a public-private effort aimed at aligning quality measures for reporting across payers to reduce provider reporting burden;
    - Changes to the quality validation audit, revisions to terminology used in quality assessment, revisions that would permit eligible professionals in ACOs to report quality apart from the ACO, and updates to align with the Physician Quality Reporting System (PQRS) and the proposed QPP, such as technical modifications to the EHR quality measure;
- Modifications to the assignment algorithm to align beneficiaries to an ACO when a beneficiary has prospectively (and voluntarily) designated an ACO professional as their “main doctor” responsible for their overall care using an automated approach;
- Establishing beneficiary protection policies related to use of the SNF 3-day waiver; and,
- Technical changes to certain rules related to merged and acquired TINs and for reconciliation of ACOs that fall below 5,000 beneficiaries.

Value-Based Payment Modifier and Physician Feedback Program

Background

Starting in 2015, CMS was required to establish a value-based payment modifier (VM) and apply it to specific physicians and groups of physicians. CMS is required to apply the VM to all physicians and groups of physicians by January 1, 2017. The VM is required to be budget neutral.

In the 2016 final Medicare physician fee schedule, CMS discussed how MACRA stipulates that the VM shall not be applied to payments for items and services furnished on or after January 1, 2019, since MACRA establishes that the Merit-based Incentive Payment System (MIPS) shall apply to payments for items and services furnished on or after January 1, 2019.