On July 15, 2016 the proposed rule *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model* was published in the Federal Register. Comments are due September 6, 2016. Below is a summary of health IT-related provisions.

Issue	**Proposal**
Telehealth	• Additions to covered telehealth services: ○ CPT codes 90967 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age; 90968 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age; 90969 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age); and 90970 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older). *Required clinical examination of catheter access site must be furnished face-to-face ○ CPT codes 99497 (advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), or surrogate); and 99498 (advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure)). ○ Telehealth Consultations for a Patient Requiring Critical Care Services (GTTT1 and GTTT2). This is a new code that would allow for the reporting of distant specialty consultations in critical care settings. It is limited to once per day per patient. • CMS is proposing to require providers to use a Place of Service (POS) code for telehealth services, which will not affect payment for services.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services	• The rule proposes requirements and processes for specification of qualified clinical decision support mechanisms (CDSMs) under the Medicare AUC program.
	• According to CMS, a CDSM is a functionality that provides persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance and health care.
	• AUC, and the CDSMs through which clinicians access AUC, must be integrated into the clinical workflow and facilitate, not obstruct, evidence-based care delivery.
	• By adhering to common interoperability standards, such as the national standards advanced through certified health IT (see 2015 edition of criteria available in the Federal Register (80 FR 62601) and described in the Interoperability Standards Advisory at https://www.healthit.gov/standards-advisory), CDSMs could both ensure integration of patient-specific data from EHRs, and allow clinicians to optimize the time spent using the tool.
	• CDSMs vary in design – CMS does not believe there is one correct approach to communicating the level of appropriateness to the ordering professional.
	  ○ Requesting feedback from commenters regarding how appropriateness ratings provided by CDSMs could be interpreted and recorded for the purposes of this program.
	• Proposing to establish requirements for qualified CDSMs.
	• CMS believes it is in the best interest of the program to establish CDSM requirements that are not prescriptive about specific IT standards. Rather, we are proposing an approach that focuses on the functionality and capabilities of qualified CDSMs.
	  ○ However, as more stakeholders and other entities including the ONC, AHRQ, and relevant standards development organizations come to consensus regarding standards for CDSMs, then CMS may consider pointing to such standards as a requirement for qualified CDSMs under this program.
	• CMS proposes to add the following requirements:
	  ○ Qualified CDSMs must make available to ordering professionals, at a minimum, specified applicable AUC that reasonably encompass the entire clinical scope of all priority clinical areas.

	○ Qualified CDSMs must be able to incorporate specified applicable AUC from more than one qualified PLE. ○ Specified applicable AUC and related documentation supporting the appropriateness of the applicable imaging service ordered must be made available within the qualified CDSM. ○ Qualified CDSM must clearly identify the appropriate use criterion consulted if the tool makes available more than one criterion relevant to a consultation for a patient's specific clinical scenario. ○ Qualified CDSM must provide to the ordering professional a determination, for each consultation, of the extent to which an applicable imaging service is consistent with specified applicable AUC or a determination of "not applicable" when the mechanism does not contain a criterion that would apply to the consultation. ○ Qualified CDSM must generate and provide to the ordering professional certification or documentation that documents which qualified CDSM was consulted, the name and NPI of the ordering professional that consulted the CDSM and whether the service ordered would adhere to applicable AUC, whether the service ordered would not adhere to such criteria, or whether such criteria was not applicable for the service ordered. ○ The documentation or certification provided by the qualified CDSM must include a unique consultation identifier. ○ The specified applicable AUC content within qualified CDSMs be updated at least every 12 months to reflect revisions or updates made by qualified PLEs to their AUC sets or to an individual appropriate use criterion. ○ Qualified CDSMs must make available for consultation specified applicable AUC that address any new priority clinical areas within 12 months of the priority clinical area being finalized by CMS. ○ Qualified mechanism must meet privacy and security standards under applicable provisions of law. Potentially applicable laws may include the HIPAA Privacy and Security rules. ○ Qualified CDSMs must provide ordering professionals aggregate feedback in the form of an electronic report on an annual basis (at minimum) regarding their consultations with specified applicable AUC. ○ In the event requirements are modified through rulemaking during the course of a qualified CDSM's 5-year approval cycle, the CDSM

	would be required to comply with the modification(s) within 12 months of the effective date of the modification.
	• CMS proposes CDSMs must apply to CMS to be specified as a qualified CDSM.
	  ○ Developers who believe their mechanisms meet the regulatory requirements must submit an application to us that documents adherence to each of the requirements to be a qualified CDSM.
	  ○ All qualified CDSMs must reapply every 5 years and their applications must be received by January 1 during the 5th year that they are qualified CDSMs.
	  ○ CMS invites comments on how they could streamline and strengthen the approval process for CDSMs in future program years. For instance, CMS may consider a testing framework for CDSMs that would validate adherence to specific standards that enable seamless incorporation of AUC across CDSMs.
	  ○ At the earliest, under this proposal, the first qualified CDSM(s) will be specified on June 30, 2017 and furnishing professionals may begin reporting as early as January 1, 2018.
	• Ordering professionals who are granted a significant hardship exception for purposes of the Medicare EHR Incentive Program payment adjustment would also be granted a significant hardship exception for purposes of the AUC consultation requirement.

Value-Based Payment Modifier and Physician Feedback Program	• CMS was unable to determine the accuracy of PQRS data submitted via EHR and QCDR for the CY 2014 performance period due to data integrity issues.
Chronic Care Management (CCM) Services	• CMS is proposing to require the initiating visit only for new patients or patients not seen within one year instead of for all beneficiaries receiving CCM services. ○ Seeking public comment on whether a period of time shorter than one year would be more appropriate. • Continue to support and encourage the use of interoperable EHRs or remote access to the care plan in providing the CCM service elements of 24/7 Access to Care, Continuity of Care, and Management of Care Transitions. • CMS proposes to remove the requirement that the individuals providing CCM after hours must have access to the electronic care plan.

	• Removes requirement that individuals providing the beneficiary with the required 24/7 access to care for urgent needs to have access to the care plan as a condition of CCM payment. • Encourage practitioners to adopt and use electronic technologies other than fax for transmission and exchange of the CCM care plan. • Removes requirement to use any specific electronic technology in managing a beneficiary's care transitions as a condition of payment for CCM services. ○ CMS is proposing to require the billing practitioner to create and exchange/transmit continuity of care document(s) timely with other practitioners and providers. • Propose to remove the language requiring beneficiary authorization for the electronic communication of his or her medical information with other treating providers as a condition of payment for CCM services, because under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR 164.506), a covered entity is permitted to use or disclose protected health information for purposes of treatment without patient authorization. • Proposes to remove requirement on the use of a qualifying certified EHR to document communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits and to document beneficiary consent. • Proposes to make similar changes to CCM requirements for Rural Health Clinics.
Accountable Care Organizations (ACOs)	• CMS is proposing to eliminate a registration process for groups submitting data using third party entities. • ACOs, ACO participants, and ACO providers/suppliers are encouraged to develop a robust EHR infrastructure, which aligns with our eligibility criteria under §425.112 that require ACOs to define care coordination processes, which may include the use of enabling technologies such as CEHRT. • The quality measure regarding EHR adoption is measured based on a sliding scale and that it is weighted twice that of any other measure for scoring purposes and determining compliance with quality performance requirements for domains. • EPs participating in an ACO under the Shared Savings Program satisfy the CQM reporting component of meaningful use for the Medicare EHR

	Incentive Program when the EP extracts data necessary for the ACO to satisfy the quality reporting requirements under the Shared Savings Program from CEHRT and when the ACO reports the ACO GPRO measures through a CMS web interface. • CMS proposes to change the specifications of the EHR measure to assess the ACO on the degree of CEHRT use by all providers and suppliers designated as ECs under the QPP proposed rule that are participating in the ACOs rather than narrowly focusing on the degree of use of CEHRT of only the primary care physicians participating in the ACO. • CMS is considering additional options regarding the treatment of the EHR measure under the Shared Savings Program in order to further enhance the importance of this measure and its impact on an ACO's quality performance score and to improve alignment with the intent of the policies proposed in the QPP proposed rule.