hfma
healthcare financial management association

CY15 Medicare Physician Fee Schedule Proposed Rule Fact Sheet

Overview

The Centers for Medicare & Medicaid Services (CMS) released a proposed rule with comment period in July that would revise payment polices under the Medicare Physician Fee Schedule (PFS) and makes other policy changes related to Medicare Part B payment. Unless otherwise noted, these proposed changes are applicable to services furnished in calendar year 2015 (CY15). The rule also includes proposals associated with PFS payments, including the Physician Quality Reporting System (PQRS), the Medicare Shared Savings Program, updates to the Physician Compare web site, and the Electronic Health Record (EHR) Incentive Program. The rule also discusses updates to the physician value-based payment modifier (value modifier), created by the Affordable Care Act (ACA), which will affect payments to certain physician groups based on the quality and cost of care they furnish to beneficiaries enrolled in the Medicare fee-for-service program, and the Physician Feedback Program. Any changes in payment rate discussed in this summary do not incorporate the impact of sequestration resulting from the Budget Control Act of 2011.

Changes in Relative Value Unit Impacts

Federal Register, page 40522

Proposed Update Summary: The Protecting Access to Medicare Act of 2014 (PAMA) has replaced the reduction in the PFS update that would otherwise occur on January 1, 2015, with a zero percent update from January 1, 2015, to March 31, 2015. CMS estimates that, based upon the zero percent update and the adjustments necessary to maintain budget neutrality for the policies in the proposed rule, the conversion (CF) for this period will be **$35.7977**. Although the PAMA provides for a zero percent update for only the first 3 months of the year, **the impacts in the proposed rule are based upon this CF being applicable throughout the year**. However, in the absence of further Congressional action, the applicable update for the remainder of the year will be based on the statutory sustainable growth rate (SGR) formula and the CF will be adjusted accordingly. By law, CMS is required to apply these updates in accordance with sections 1848(d) and (f) of the Social Security Act (the Act), and any negative updates can only be averted by an Act of Congress. While the Congress has provided temporary relief from negative updates every year since 2003, CMS notes that a long-term solution is critical. Table 60 of the rule shows the proposed payment impact on PFS services.

Anesthesia CF

The anesthesia CF in effect in CY14 is **$17.2283**.

Background: The annual update to the PFS CF is calculated based on a statutory formula that measures actual versus allowed or ''target'' expenditures, and applies a sustainable growth rate SGR calculation intended to control growth in aggregate Medicare expenditures for physicians' services. This update methodology is typically referred to as the ''SGR'' methodology, although the SGR is only one component of the formula. Medicare PFS payments for services are not withheld if the percentage increase in actual expenditures exceeds the SGR. Rather, the PFS update, as specified in section 1848(d)(4) of the Act, is adjusted to eventually bring actual expenditures back in line with targets. If actual expenditures exceed allowed expenditures, the update is reduced. If actual expenditures are less than allowed expenditures, the update is increased. CMS provides its most recent estimate of the SGR and physician update for CY15 on the CMS web site at:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/SustainableGRatesConFact/index.html?redirect=/SustainableGRatesConFact/

Resource-Based Practice Expense (PE) RVUs

Federal Register, pages 40323-40334

Proposed Update Summary:
CMS discusses several CY15 proposals and revisions related to direct PE inputs for specific services. The proposed direct PE inputs are included in the proposed rule CY15 direct PE input database, which is available on the CMS web site under downloads for the CY15 PFS proposed rule at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html

Background: Practice expense (PE) is the portion of the resources used in furnishing a service that reflects the general categories of physician and practitioner expenses. CMS develops PE RVUs by considering the direct and indirect practice resources involved in furnishing each service. CMS established the resource-based PE RVUs for each physicians' service in a final rule, published on November 2, 1998, effective for services furnished in CY99. Based on the requirement to transition to a resource-based system for PE over a 4- year period, payment rates were not fully based upon resource-based PE RVUs until CY02.

Geographic Practice Cost Indices (GPCIs)

Federal Register, pages 40355-40356

Proposed Update Summary: Section 102 of the PAMA extended the 1.0 work geographic practice cost indices **(**GPCI) floor through March 31, 2015. Therefore, the CY15 work GPCIs and summarized geographic adjustment factors (GAFs) have been revised to reflect the 1.0 work floor. Additionally, as required by sections 1848(e)(1)(G) and 1848(e)(1)(I) of the Act, the 1.5 work GPCI floor for Alaska and the 1.0 PE GPCI floor for frontier states are permanent, and therefore, applicable in CY15. Addenda D and E of the proposed rule contain CY15 GPCIs and summarized GAFs. CMS also noted that it does not adjust the medical equipment, supplies, and other miscellaneous expenses component of the PE GPCI because it continues to believe there is a national market for these items such that there is not a significant geographic variation in relative costs. Additionally, CMS updated the GPCI cost share weights consistent with the modifications made to the 2006-based Medicare Economic Index cost share weights in the CY14 final rule. As discussed in that rule, use of the revised GPCI cost share weights changed the weighting of the subcomponents within the PE GPCI (employee wages, office rent, purchased services, and medical equipment and supplies).

Background: Section 1848(e)(1)(A) of the Act requires CMS to develop separate GPCIs to measure relative cost differences among localities compared to the national average for each of the three fee schedule components (that is, work, PE, and MP). Although the statute requires that the PE and MP GPCIs reflect the full relative cost differences, section 1848(e)(1)(A)(iii) of the Act requires that the work GPCIs reflect only one-quarter of the relative cost differences compared to the national average. Additionally, section 1848(e)(1)(E) of the Act provided for a 1.0 floor for the work GPCIs, which was set to expire on March 31, 2014. However, section 102 of the PAMA extended application of the 1.0 floor to the work GPCI through March 31, 2015. CMS is required to review and, if necessary, adjust the GPCIs at least every 3 years. If more than

one year has elapsed since the date of the most recent previous GPCI adjustment, the adjustment to be applied in the first year of the next adjustment is half of the adjustment that otherwise would be made. CMS completed a review and finalized updated GPCIs in the CY14 PFS final rule. Since the last GPCI update had been implemented over 2 years, CY11 and CY12, CMS phased in half of the latest GPCI adjustment in CY14. CMS also revised the cost share weights that correspond to all three GPCIs in the CY14 PFS final rule. It calculated a corresponding geographic adjustment GAF for each PFS locality. The GAFs are a weighted composite of each area's work, PE, and MP GPCIs using the national GPCI cost share weights.

Telehealth Services

Federal Register, pages 40356-40359

Proposed Update Summary: CMS received several requests in CY13 to add various services as Medicare telehealth services effective for CY15. CMS proposes to add the following codes to the telehealth list on a category 1 basis:

- Psychotherapy services - CPT codes 90845, 90846 and 90847
- Prolonged service office - CPT codes 99354 and 99355
- Annual wellness visit - HCPCS codes G0438 and G0439

Because the list of Medicare telehealth services has grown quite lengthy, and given the many other mechanisms by which CMS can make the public aware of the list of Medicare telehealth services for each year, CMS is proposing to revise § 410.78(b) by deleting the description of the individual services for which Medicare payment can be made when furnished via telehealth. CMS would continue its current policy to address requests to add to the list of telehealth services through the PFS rulemaking process so that the public would have the opportunity to comment on additions to the list. CMS is also proposing to revise § 410.78(f) to indicate that a list of Medicare telehealth codes and descriptors is available on its web site.

Background: Generally, for Medicare payments to be made for telehealth services under the PFS, several conditions must be met. Specifically, the service must be on the Medicare list of telehealth services, and meet the following other requirements for coverage.

- The service must be furnished via an interactive telecommunications system.
- The practitioner furnishing the service must meet the telehealth requirements, as well as the usual Medicare requirements.
- The service must be furnished to an eligible telehealth individual.
- The individual receiving the services must be in an eligible originating site.

When all of these conditions are met, Medicare pays an originating site fee to the originating site, and provides separate payment to the distant site practitioner for furnishing the service. Medicare telehealth services can be furnished only to an eligible telehealth beneficiary in a qualifying originating site. An *originating site* is defined as one of the specified sites where an eligible telehealth individual is located at the time the service is being furnished via a telecommunications system. As specified in regulations at § 410.78(b), CMS generally requires that a telehealth service be furnished via an interactive telecommunications system. Medicare telehealth services may be furnished to an eligible telehealth individual notwithstanding the fact that the practitioner furnishing the telehealth service is not at the same location as the

beneficiary. An eligible telehealth individual is an individual enrolled under Part B who receives a telehealth service furnished at an originating site. Effective January 1, 2014, CMS changed its policy so that geographic eligibility for an originating site would be established and maintained on an annual basis, consistent with other telehealth payment policies. Geographic eligibility for Medicare telehealth originating sites for each calendar year is now based upon the status of the area as of December 31 of the prior calendar year.

Removal of Employment Requirements for Services Furnished ‘‘Incident to’’ Rural Health Clinics and Federally Qualified Health Center Visits

Federal Register, pages 40376- 40378

Proposed Update Summary: To provide rural health clinics (RHCs) and Federally qualified health centers (FQHCs) with as much flexibility as possible to meet their staffing needs, CMS is proposing to revise, remove, and delete many of the requirements pertaining to “incident” to services provided by RHC and FQHC visits. Specifically, CMS would remove the requirement that services furnished incident to an RHC or FQHC visit must be furnished by an employee of the RHC or FQHC to allow nurses, medical assistants, and other auxiliary personnel to furnish incident to services under contract in RHCs and FQHCs. CMS believes that removing the requirements will provide RHCs and FQHCs with additional flexibility without adversely impacting the quality or continuity of care.

CMS will adopt a new condition of payment by requiring compliance with state laws for services furnished incident to a physician’s or other practitioner’s professional services. Specifically, CMS will add new language to state that services and supplies must be furnished in accordance with applicable state law, and will amend the definition of auxiliary personnel to require that the individual providing “incident to” services meet any applicable requirements to provide the services, including licensure, imposed by the state in which the services are being furnished. CMS believes this requirement will protect the health and safety of Medicare beneficiaries and enhance its ability to recover federal dollars when care is not delivered in accordance with state laws.

Background: RHCs and FQHCs furnish physicians’ services; services and supplies incident to the services of physicians; nurse practitioner (NP), physician assistant (PA), certified nurse-midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services; and services and supplies incident to the services of NPs, PAs, CNMs, CPs, and CSWs. In the May 2, 2014, final rule, CMS removed the regulatory requirements that NPs, PAs, CNMs, CSWs, and CPs furnishing services in a RHC must be employees of the RHC. RHCs are now allowed to contract with NPs, PAs, CNMs, CSWs, and CPs, as long as at least one NP or PA is employed by the RHC, as required under section 1861(aa)(2)(iii) of the Act. Services furnished in RHCs and FQHCs by nurses, medical assistants, and other auxiliary personnel are considered ‘‘incident to’’ a RHC or FQHC visit furnished by a RHC or FQHC practitioner. Services furnished incident to an RHC or FQHC visit must be furnished by an employee of the RHC or FQHC. Since there is no separate benefit under Medicare law that specifically authorizes payment to nurses, medical assistants, and other auxiliary personnel for their professional services, they cannot bill the program directly and receive payment for their services, and can only be remunerated when furnishing services to Medicare patients in an ‘‘incident to’’ capacity.

Chronic Care Management

Federal Register, pages 40364-40368

Proposed Update Summary

CCM Services

Chronic care management (CCM) is a unique PFS service designed to pay separately for non face-to-face care coordination services furnished to Medicare beneficiaries with two or more chronic conditions. In the CY14 PFS final rule, CMS indicated that, to recognize the additional resources required to provide CCM services to patients with multiple chronic conditions, it was creating the following code to use for reporting this service:

- ***GXXX1*** Chronic care management services furnished to patients with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; 20 minutes or more; per 30 days.

CCM and TCM Services Furnished Incident to a Physician's Service Under General Physician Supervision

In the CY14 PFS final rule, CMS discussed how the policies relating to services furnished incident to a practitioner's professional services apply to CCM services. Specifically, CMS addressed the policy for counting clinical staff time for services furnished incident to the billing practitioner's services toward the minimum amount of service time required to bill for CCM services. CMS established an exception to the usual rules that apply to services furnished incident to the services of a billing practitioner. The exception created is one to the generally applicable requirement that ''incident to'' services must be furnished under direct supervision. In the proposal, however, CMS would revise the policy that it adopted in the CY14 PFS final rule to amend its regulations to codify the requirements for CCM services furnished incident to a practitioner's services. Specifically, CMS proposes to remove the requirement that, in order to count the time spent by clinical staff providing aspects of CCM services toward the CCM time requirement, the clinical staff person must be a direct employee of the practitioner or the practitioner's practice.

CMS is also proposing to remove the restriction that services provided by clinical staff under general (rather than direct) supervision may be counted only if they are provided outside of the practice's normal business hours. In conjunction with this proposed revision to the requirements for CCM services provided by clinical staff incident to the services of a practitioner, CMS is also proposing to adopt the same requirements for equivalent purposes in relation to TCM services. Therefore, CMS is proposing to revise regulation at § 410.26, which sets out the applicable requirements for ''incident to'' services, to permit transitional care management (TCM) and CCM services provided by clinical staff incident to the services of a practitioner to be furnished under the general supervision of a physician or other practitioner.

Scope of Services and Standards for CCM Services

For FY15, CMS is proposing a new scope of service requirement for electronic care planning capabilities and electronic health records. Under the proposal, CCM services would be furnished with the use of an electronic health record or other health information technology (IT) or health

information exchange platform that includes an electronic care plan that is accessible to all providers within the practice, including being accessible to those who are furnishing care outside of normal business hours, and that is available to be shared electronically with care team members outside of the practice. To ensure all practices have adequate capabilities to meet EHR requirements, the practitioner must utilize EHR technology certified by a certifying body authorized by the National Coordinator for Health Information Technology to an edition of the electronic health record certification criteria identified in the then-applicable version of 45 CFR part d170. Practitioners furnishing CCM services beginning in CY15 would be required to utilize an EHR certified to at least those 2014 edition certification criteria. Given these certification criteria, EHR technology would be certified to capture data and ultimately produce summary records according to the HL7 Consolidated Clinical Document Architecture standard.

Payment of CCM Services in CMS Models and Demonstrations
CMS models and demonstrations, such as the Multi-payer Advanced Primary Care Practice Demonstration, and the Comprehensive Primary Care Initiative, both include payments for care management services that closely overlap with the scope of service for the new chronic care management services code. In these two initiatives, primary care practices are receiving per beneficiary per month (PBPM) payments for care management services furnished to Medicare fee-for-service beneficiaries attributed to their practices. CMS proposes that practitioners participating in one of these two models ***may not*** bill Medicare for CCM services furnished to any beneficiary attributed to the practice for purposes of participating in one of these initiatives, as it believes payment for CCM services would be duplicative payment for substantially the same services for which payment is made through the PBPM payment. CMS proposes that these practitioners ***may*** bill Medicare for CCM services furnished to eligible beneficiaries who are not attributed to the practice for the purpose of the practice's participation as part of one of these initiatives.

Background: CCM is a unique PFS service designed to pay separately for non-face-to-face care coordination services furnished to Medicare beneficiaries with two or more chronic conditions. Under current PFS policy, the payment for non face-to-face care management services is bundled into the payment for face-to-face evaluation and management (E/M) visits because care management is a component of those E/M services. In the CY14 final rule with comment period, CMS defined the elements of the scope of service for CCM services required in order for a practitioner to bill Medicare for CCM services. In addition, CMS indicated that it intended to develop standards for practices that furnish CCM services to ensure that the practitioners who bill for these services have the capability to fully furnish them. In the CY14 PFS final rule with comment period, CMS finalized a policy to pay separately for care management services furnished to Medicare beneficiaries with two or more chronic conditions beginning in 2015.

Physician Compare Website

Federal Register, pages 40385-40391

Proposed Update Summary:
Proposals for Public Data Disclosure on Physician Compare in 2015 and 2016
CMS is continuing the expansion of public reporting on Physician Compare by proposing to make an even broader set of quality measures available for publication on the web site. As a result, CMS is now proposing to increase the measures available for public reporting. CMS also proposes to expand public reporting of group-level measures by making all 2015 Physician

Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) measure sets across group reporting mechanisms—GPRO web interface, registry, and EHR—available for public reporting on Physician Compare in CY16 for groups of two or more eligible professionals (EPs,) as appropriate by reporting mechanism. Similarly, all measures reported by Shared Savings Program accountable care organizations (ACOs) would be available for public reporting on Physician Compare. These measures meet the public reporting criteria of a minimum sample size of 20 patients.

CMS would include an indicator of which reporting mechanism was used, and only measures deemed statistically comparable would be included on the site. CMS proposes to publicly report all measures submitted, reviewed, and found to be statistically valid and reliable in the Physician Compare downloadable file. As is the case for all measures published, group practices will be given a 30-day preview period to view their measures as they will appear on Physician Compare prior to the measures being published. As in previous years, CMS will detail the process for the 30-day preview, and provide a detailed timeline and instructions for preview in advance of the start of the preview period. ACOs will be able to view their quality data that will be publicly reported on Physician Compare through the ACO Quality Reports, which will be made available to ACOs for review at least 30 days prior to the start of public reporting on Physician Compare.

In addition to making all 2015 PQRS GPRO measures available for public reporting, CMS seeks comment on creating composites using 2015 data and publishing composite scores in 2016 by grouping measures based on the PQRS GPRO measure groups, if technically feasible. CMS also proposes publicly reporting in CY16 patient experience data from 2015 for all group practices of two or more EPs, who meet the specified sample size requirements and collect data via a CMS-specified certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) vendor. Also, for group practices, CMS propose to publicly report for 2015 data on Physician Compare in 2016 the 12 summary survey measures previously finalized for 2014 data. CMS previously finalized in the 2014 PFS final rule with comment period that 20 2014 PQRS measures for individual EPs collected via registry, EHR, or claims would be available for public reporting in late 2015, if technically feasible. CMS proposes to expand on this in two ways. First, it would publicly report these same 20 measures for 2013 PQRS data in early 2015. Second, it would make all individual EP-level PQRS measures collected via registry, EHR, or claims available for public reporting on Physician Compare for data collected in 2015 to be publicly reported in late CY16, if technically feasible.

Finally, CMS proposes to make available on Physician Compare, 2015 Qualified Clinical Data Registry (QCDR) measure data collected at the individual level or aggregated to a higher level of the QCDR's choosing—such as the group practice level, if technically feasible. Measures collected via QCDRs must also meet the established public reporting criteria, including a 20 patient minimum sample size. As with PQRS data, CMS proposes to publicly report all measures submitted and reviewed, and deemed valid and reliable in the Physician Compare downloadable file. See Table 20 in the proposed rule that summarizes the Physician Compare proposals detailed in this section.

Background: The Physician Compare website contains information on physicians enrolled in the Medicare program, as well as information on other EPs who participate in the PQRS. The overarching goal of the site is to provide consumers with quality of care information to make informed decisions about their health care, while encouraging clinicians to improve on the quality of care they provide to their patients. In accordance with section 10331 of the ACA, CMS intends

to utilize Physician Compare to publicly report physician performance results. CMS launched the first phase of Physician Compare on December 30, 2010, and has continued to build on and improve the website since this initial launch. CMS continues to implement its plan for a phased approach to public reporting performance information on Physician Compare.

CMS is required to submit a report to the Congress by January 1, 2015, on Physician Compare development, and include information on the efforts and plans to collect and publish data on physician quality and efficiency, and on patient experience of care in support of value-based purchasing and consumer choice.

Physician Quality Reporting System (PQRS)

Federal Register, pages 40391-40474

Proposed Update Summary: This section contains the proposed requirements for the Physician Quality Reporting System (PQRS). These proposed requirements will primarily focus on the proposals related to the 2017 PQRS payment adjustment, which will be based on an EP's or a group practice's reporting of quality measures data during the 12-month calendar year reporting period occurring in 2015 (that is, January 1 through December 31, 2015). CMS notes that in developing these proposals, it focused on aligning its requirements with other quality reporting programs, such as the Medicare EHR Incentive Program for Eligible Professionals, the Physician Value-Based Payment Modifier (VM), and the Medicare Shared Savings Program.

Proposed Changes to the Requirements for the Qualified Registry

Under the proposal, qualified registries would be required to be able to report on all cross-cutting measures specified in Table 21 of the rule for which the registry's participating EPs are able to report. CMS proposes to extend the deadline for qualified registries to submit quality measures data, including, but not limited to, calculations and results, to March 31 following the end of the applicable reporting period (for example, March 31, 2016, for reporting periods ending in 2015).

Requirements for the Direct EHR and EHR Data Submission Vendor Products That Are CEHRT

Direct EHRs and EHR data submission vendors must comply with CMS Implementation Guides for both the QRDA–I and QRDA–III data file formats. The Implementation Guides for 2014 are available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Guide_QRDA_2014eCQM.pdf. Updated guides for 2015, when available, will be posted on the CMS EHR Incentive Program web site at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/. CMS proposes to continue applying these requirements to direct EHR products and EHR data submission vendor products for 2015 and beyond. CMS also proposes to have the EP or group practice provide the CMS EHR certification number of the product used by the EP or group practice for direct EHRs and EHR data submission vendors. Additionally, CMS seeks comment on whether to propose in future rulemaking to allow more frequent submissions of data, such as quarterly or year-round submissions, rather than having only one opportunity to submit quality measures data as is the current process.

Proposed Changes to the Requirements for the QCDR

In the CY14 PFS final rule with comment period, CMS established certain requirements for entities to become QCDRs for the purpose of having their participating EPs meet the criteria for satisfactory participation in a QCDR for purposes of the PQRS incentives and payment

adjustments. Specifically, in accordance with the final criterion that required EPs to report on at least one outcome measure, CMS required that an entity possess at least one outcome measure for which its participating EPs may report. Under the 2015 proposal, CMS would amend the requirement for the 2017 PQRS payment adjustment to require a QCDR to possess at least three outcome measures (or, in lieu of three outcome measures, at least two outcome measures, and at least one of the following other types of measures: resource use, patient experience of care, or efficiency/appropriate use). Additionally, beginning with the criteria for satisfactory participation for the 2017 PQRS payment adjustment, a QCDR would submit quality measures data for a maximum of 30 non-PQRS measures. This proposed limit does not apply to measures contained in the PQRS measure set, as QCDRs can report on as many measures in the PQRS measure set as they wish. CMS' experience during the 2014 self-nomination process shed light on clarifications needed on what is considered a non-PQRS measure. To clarify the definition of non-PQRS measures, CMS proposes the following parameters for a measure to be considered a non-PQRS measure:

- A measure that is not contained in the PQRS measure set for the applicable reporting period
- A measure that may be in the PQRS measure set, but has substantive differences in the manner that it is reported by the QCDR.

CMS proposes to require that the entity make available to the public the quality measures data for which its EPs report in order to serve as a QCDR under the PQRS for reporting periods beginning in 2015. Because of ongoing interest in providing transparency to the public for quality measures data that is reported under the PQRS, CMS proposes the requirement that an entity make available to the public the quality measures data for which its EPs report. CMS also proposes that, at a minimum, the QCDR publicly report the title and description of the measures it reports for purposes of the PQRS, as well as the performance results for each measure it reports. The QCDR must have the quality measures data by April 31 of the year following the applicable reporting period (that is, April 31, 2016, for reporting periods occurring in 2015). Also, beginning in 2015, in situations where an entity may not meet the requirements of a QCDR solely on its own but, in conjunction with another entity, CMS proposes circumstances under which it would be able to meet the requirements of a QCDR, and therefore, be eligible for qualification. In accordance with its proposal to extend this deadline for qualified registries, CMS proposes to extend the deadline for QCDRs to submit quality measures data calculations and results by March 31 following the end of the applicable reporting period (that is, March 31, 2016, for reporting periods occurring in 2015).

Proposed Changes to the GPRO Web Interface

To provide timelier feedback on performance on CAHPS for PQRS, CMS proposes to modify the deadline that a group practice must register to participate in the GPRO to June 30 of the year in which the reporting period occurs (that is, June 30, 2015, for reporting periods occurring in 2015). CMS also seeks comment on whether to allow more frequent submissions of data, such as quarterly or year-round submissions, rather than having only one opportunity to submit quality measures data as is the current process.

Satisfactory Reporting for Individual Eligible Professionals for the 2017 PQRS Payment Adjustment

To be consistent with the satisfactory reporting criterion finalized for the 2014 PQRS incentive, CMS would modify § 414.90(j) and propose the following criterion for individual eligible professionals reporting via claims and registry: for the 12-month reporting period for the 2017 PQRS payment adjustment, the EP would report at least nine measures, covering at least three of the National Quality Strategy (NQS) domains AND report each measure for at least 50 percent of the EP's Medicare Part B fee-for-service (FFS) patients seen during the reporting period to which the measure applies. Of the measures reported, if the EP sees at least one Medicare patient in a face-to-face encounter, the EP would report on at least two measures contained in the proposed cross-cutting measure set specified in Table 21 of the rule. If less than nine measures apply to the EP, it would report up to eight measure(s), AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a zero percent performance rate would not be counted.

Proposed Criterion for Satisfactory Reporting of via EHR for Individual Eligible Professionals for the 2017 PQRS Payment Adjustment

To be consistent with the criterion CMS finalized for the 2014 PQRS incentive, as well as continue to align with the final criterion for meeting the clinical quality measure (CQM) component of achieving meaningful use under the Medicare EHR Incentive Program:

- CMS proposes the EP would report nine measures covering at least three of the NQS domains. If an EP Certified EHR technology (CEHRT) does not contain patient data for at least nine measures covering at least three domains, then it would be required to report all of the measures for which there is Medicare patient data. An EP would be required to report on at least one measure for which there is Medicare patient data.

Proposed Criterion for the Satisfactory Reporting of Individual Quality Measures via Claims and Registry

To be consistent with the satisfactory reporting criterion CMS finalized for the 2014 PQRS incentive, it proposes the following criterion for individual EPs reporting via claims and registry:

- For the 12-month reporting period for the 2017 PQRS payment adjustment, the EP would report at least nine measures, covering at least three of the NQS domains AND report each measure for at least 50 percent of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the EP sees at least one Medicare patient in a face-to-face encounter, it would report on at least two measures contained in the proposed cross-cutting measure set specified in Table 21 of the rule.

Proposed Criterion for the Satisfactory Participation for Individual Eligible Professionals in a QCDR

To be consistent with the number of measures reported for the satisfactory participation criterion finalized for the 2014 PQRS incentive, CMS proposes the following criterion for EPs to satisfactorily participate in a QCDR for the 2017 PQRS payment adjustment:

- For the 12-month reporting period for the 2017 PQRS payment adjustment, the EP would report at least nine measures available for reporting under a QCDR covering at least three

of the NQS domains, AND report each measure for at least 50 percent of the EPs patients. Of these measures, the EP would report on at least three outcome measures, OR, if three outcomes measures are not available, report on at least two outcome measures, and at least one of the following types of measures: resource use, patient experience of care, or efficiency/ appropriate use.

Proposed Criteria for Satisfactory Reporting for Group Practices Selected to Participate in the Group Practice Reporting Option (GPRO)

For a group practice to participate in the PQRS GPRO in lieu of participating as individual EPs, a group practice is required to register to participate in the PQRS GPRO. CMS proposes to change the deadline by which a group practice must register to participate in the GPRO to June 30 of the applicable 12-month reporting period (that is, June 30, 2015, for reporting periods occurring in 2015). This proposed change would allow CMS to provide timelier feedback, while still providing group practices with over six months to determine whether they should participate in the PQRS GPRO or, in the alternative, participate in the PQRS as individual eligible professionals.

Proposed Criteria for Satisfactory Reporting on PQRS Quality Measures via the GPRO Web Interface

CMS proposes to incorporate the following criterion for the satisfactory reporting of PQRS quality measures for group practices registered to participate in the GPRO:

- For the 12-month reporting period for the 2017 PQRS payment adjustment, for groups practices of 25–99 EPs, report on all measures included in the web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. Under the rule, CMS would reduce the patient sample size a group practice is required to report quality measures data from 411 to 248. *CMS proposes to align the web interface beneficiary attribution method with the Value-Based Payment Modifier's proposed method of attribution.*

Proposed Criteria for Satisfactory Reporting on Individual PQRS Quality Measures for Group Practices Registered To Participate in the GPRO via a CMS Certified Survey Vendor for the 2017 PQRS Payment Adjustment

Consistent with the criterion finalized for the 2014 PQRS incentive and the group practice reporting requirements, CMS proposes the following 3 options (of which a group practice would be able to select 1) for satisfactory reporting for the 2017 PQRS payment adjustment for group practices comprised of 25 or more EPs:

- ***Proposed Option 1:*** The group practice would report all CAHPS for PQRS survey measures via a certified vendor, and at least six additional measures, outside of CAHPS for PQRS, covering at least two of the NQS domains using the qualified registry. If less than 6 measures apply to the group practice, it must report all applicable measures. If any EP in the group practice sees at least one Medicare patient in a face-to-face encounter, it would be required to report on at least one measure in the cross-cutting measure set specified in Table 21 of the rule.

- ***Proposed Option 2:*** The group practice would report all CAHPS for PQRS survey measures via a certified vendor, and at least six additional measures, outside of CAHPS for PQRS, covering at least two of the NQS domains using direct EHR or EHR data submission vendor. If less than six measures apply to the group practice, it must report all applicable measures.

- ***Proposed Option 3:*** The group practice would report all CAHPS for PQRS survey measures via a certified vendor, and all measures included in the GPRO web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries.

Criteria for Reporting on Individual PQRS Quality Measures for Group Practices Participating in GPRO Reporting CAHPS for PQRS Survey Measures via a CMS-Certified Survey Vendor for 2018

CMS proposes to require that, in conjunction with other satisfactory reporting criteria established in future years, beginning with the 12-month reporting period for the 2018 PQRS payment adjustment, and for subsequent years, group practices comprised of 25 or more EPs that are participating in the GPRO report and pay for the collection of the CAHPS for PQRS survey measures. CMS understands that the cost of administering the CAHPS for PQRS survey may be significant, so it is proposing this requirement well in advance of the year in which it would be first effective in order to provide group practices with early notice so that their practices may adjust accordingly.

The Consumer Assessment of Healthcare Providers Surgical Care Survey (S–CAHPS)

In addition to CAHPS for PQRS, CMS received comments last year supporting the inclusion of the Consumer Assessment of Healthcare Providers Surgical Care Survey (S–CAHPS). The commenters stated that the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG–CAHPS) survey would not accurately reflect the care provided by single- or multispecialty surgical or anesthesia groups. CMS agrees with the commenters on the importance of allowing for the administration of S–CAHPS reporting, and wishes to allow for reporting of S–CAHPS in the PQRS for reporting mechanisms other than the QCDR. However, at this time, due to the cost and time it would take to find vendors to collect S–CAHPS data, CMS notes that it is not technically feasible to implement the reporting of the S–CAHPS survey for the 2017 PQRS payment adjustment.

Proposed Cross-Cutting Measure Set for 2015 and Beyond

In accordance with its proposed criteria for the satisfactory reporting of PQRS measures for the 2017 PQRS payment adjustment via claims and registry that requires an EP or group practice to report on at least 2 cross-cutting measures, CMS is proposing the 18 cross-cutting measure set specified in Table 21 for 2015 and beyond. CMS notes that its rationale for proposing each of these measures is found below each measure description. CMS also indicates the PQRS reporting mechanism or mechanisms through which each proposed measure could be submitted.

Proposed New PQRS Measures Available for Reporting for 2015 and Beyond

CMS provides additional measures that it proposes to include in the PQRS measure set for CY15 and beyond. Not all of the proposed cross-cutting measures may appear in Table 22 of the proposed rule, as some of the proposed cross-cutting measures specified in the table were finalized in the CY13 or CY14 PFS final rules. The table also indicates the PQRS reporting

mechanism or mechanisms through which each proposed measure could be submitted. Tables 23 through 25 of the rule also contain information pertaining to quality measures beginning in 2015.

PQRS Measures Groups

In the CY14 PFS proposed rule, CMS proposed to increase the number of measures that may be included in a measures group from a minimum of four measures to a minimum of six. CMS has worked with the measure owners and developers and is again proposing to increase the number of measures from a minimum of four to six. CMS is proposing to define a measures group as a subset of six or more PQRS measures that have a particular clinical condition or focus in common. In addition, CMS is proposing two new measures groups that will be available for reporting in the PQRS beginning in 2015: ***the sinusitis measures group*** and ***the acute otits externa (AOE) measures group.***

Furthermore, CMS proposes to remove the following measures groups for reporting beginning in 2015:

- Perioperative care measures group
- Back pain measures group
- Cardiovascular prevention measures group
- ischemic vascular disease (IVD) measures group
- Sleep Apnea measures group
- Chronic obstructive pulmonary disease (COPD) measures group

Tables 26 through 48 of the rule specifies CMS's proposed measure groups in light of the proposal to increase the minimum number of measures in a previously established measures groups, so that each group contains at least six measures. If these proposals are finalized, the GPRO measure set will contain 21 measures available for reporting.

The Clinician Group Consumer Assessment of CAHPS Survey

In the CY 14 PFS final rule with comment period, CMS made an error, classifying the CAHPS for PQRS survey under the care coordination and communication NQS domain. The CAHPS for PQRS survey has typically been classified under the Person and Caregiver-Centered Experience and Outcomes domain, as the CAHPS for PQRS survey assesses beneficiary experience of care and outcomes. Therefore, CMS is proposing to reclassify the CAHPS for PQRS survey under the Person and Caregiver-Centered Experience and Outcomes domain.

Requirements and Other Considerations for the Selection of PQRS Quality Measures for Meeting the Criteria for Satisfactory Participation in a QCDR for 2014 and Beyond

In the CY14 PFS final rule with comment period, CMS finalized requirements related to the parameters for the measures that would have to be reported to CMS by a QCDR for the purpose of its individual eligible professionals meeting the criteria for satisfactory participation under the PQRS. Although CMS is not proposing to remove any of the requirements it finalized related to these parameters, it is proposing to make several modifications.

Informal Review

In the CY13 PFS final rule with comment period CMS established that an eligible professional electing to utilize the informal review process must request an informal review by February 28 of the year in which the payment adjustment is being applied. Because PQRS data is used to establish the quality composite of the Value-Based Payment Modifier, CMS believes it is

necessary to expand the informal review process to allow for some limited corrections of the PQRS data to be made. Therefore, it proposes to modify the payment adjustment informal review deadline to within 30 days of the release of the feedback reports.

Background: In the CY13 PFS final rule with comment period, CMS finalized certain requirements for the 2013 and 2014 PQRS incentives, and for the 2015 and 2016 PQRS payment adjustments. CMS also finalized certain requirements for future years, such as the reporting periods for the PQRS payment adjustment, as well as requirements for the various PQRS reporting mechanisms. In the CY14 PFS proposed rule, CMS proposed to change some requirements for the 2014 PQRS incentive and 2016 PQRS payment adjustment, and to make changes to the PQRS measure set. Furthermore, it introduced its proposals for a new PQRS reporting option—satisfactory participation in a QCDR.

Medicare Shared Savings Program

Federal Register, pages 40475-40492

Proposed Update Summary: Under the proposed changes, CMS would add 12 new measures and retire eight. CMS is also proposing to rename the EHR measure in order to reflect the transition from an incentive payment to a payment adjustment under the EHR Incentive Program, and to revise the component measures within the diabetes and coronary artery disease (CAD) composites. In total, CMS would use 37 measures for establishing the quality performance standards that ACOs must meet to achieve shared savings. Although the total number of measures would increase from the current 33 measures to 37 measures, CMS does not anticipate that this would increase the reporting burden on ACOs. The increased number of measures is accounted for by measures that would be calculated by CMS using administrative claims data or from a patient survey. The total number of measures that the ACO would need to directly report through the CMS web site interface would actually decrease by one, in addition to removing redundancy in measures reported. As part of these proposed changes, CMS would replace the current five component diabetes composite measure with a new four component diabetes composite measure. In addition, it would replace the current two component coronary artery disease composite measure with a new four component CAD composite measure. Twenty-one of the measures would be reported by ACOs through the GPRO web interface and scored as 15 measures.

Proposed Changes to the Quality Measures Used in Establishing Quality Performance Standards that ACOs Must Meet to be Eligible for Shared Savings

Since the November 2011 Shared Savings Program final rule, CMS has continued to review the quality measures used for the Shared Savings Program to ensure that they are up to date with current clinical practice and are aligned with the GPRO web interface reporting for PQRS. Based on the reviews, CMS has identified a number of proposed measure additions, deletions, and other revisions that it believes would be appropriate for the Shared Savings Program. Under the proposed measure revisions, ACOs would be assessed on 37 measures annually, an increase of 4 measures. However, CMS believes the measures chosen are more outcome-oriented and would ultimately reduce the reporting burden on ACOs. CMS provides a detailed description of proposed changes that would be effective for the 2015 reporting period, and would be reported by ACOs in early 2016. Table 50 of the proposed rule offers an overview of the proposed changes. Tables 51, 52, and 53 of the proposed rule display the current number of measures by domain, total points, and domain weights used for scoring purposes, a summary of the proposed number of measures by domain and the resulting total points and domain weights that would be

used for scoring purposes, and retired/replaced measures. Finally, CMS proposes that these measures would become effective beginning with the 2015 reporting period, and 2015 performance year. All 37 measures would be phased in for ACOs with 2015 start dates according to the phase-in schedule in Table 50 of the proposed rule.

Quality Performance Benchmarks

CMS proposes that when the national FFS data results in the 90th percentile for a measure are greater than or equal to 95 percent, it would use flat percentages for the measure, similar to its policy of using flat percentages when the 60th percentile is greater than 80 percent to address clustered measures. Also, benchmarks would be updated every two years. CMS believe two years is an appropriate amount of time because the Shared Savings Program is relatively new and it does not have extensive experience in setting benchmarks under the Shared Savings Program. The existing quality performance benchmarks, which are based on data submitted in 2013 for the 2012 reporting period would apply for a total of two performance years (2014 and 2015) after which CMS would reset the benchmarks for all ACOs based on data for the 2014 reporting period that is reported during 2015.

Rewarding Quality Improvement

ACOs must meet a CMS-specified quality performance standard in order to be eligible to share in savings. The Shared Savings Program quality performance standard currently consists of a set of quality measures spanning four domains, which include patient/caregiver experience of care, care coordination/patient safety, preventive health, and at-risk populations. CMS recognizes that rewards for both quality attainment, as well as quality improvement are not always built in to pay-for-performance initiatives. In the November 2011 final rule establishing the Shared Savings Program, CMS indicated in response to comments that it believes the approach of offering more points for better quality performance also offers an implicit incentive for continuous quality improvements, since it incorporates a sliding scale in which higher levels of quality performance translate to higher sharing rates. However, ACOs and other stakeholders have suggested that the current quality points scale does not adequately reward ACOs for both quality attainment and improvement. Therefore, CMS proposes to revise the existing quality scoring strategy to explicitly recognize and reward ACOs that make year-to-year improvements in their quality performance scores on individual measures.

To develop such an approach, CMS looked to the Medicare Advantage (MA) program, which has already successfully developed and implemented a formula for measuring quality improvement. Therefore, CMS proposes to add a quality improvement measure to award bonus points for quality improvement to each of the existing four quality measure domains. For each quality measure domain, it would award an ACO up to two additional bonus points for quality performance improvement on the quality measures within the domain. These bonus points would be added to the total points that the ACO achieved within each of the four domains. Under this proposal, the total possible points that can be achieved in a domain, including up to 2 bonus points, could not exceed the current maximum total points achievable within the domain. The quality improvement measure scoring for a domain would be based on the ACO's net improvement in quality for the other measures in the domain. The calculation of the quality improvement measure for each domain would generally be based on the formula used for the MA five star rating program, as follows:

Improvement Change Score = score for a measure in performance year minus score in previous performance year.

For purposes of determining quality improvement and awarding bonus points, CMS would include all of the individual measures within the domain, including both pay-for- reporting measures and pay-for-performance measures. In determining improvement, the actual performance score achieved by the ACO on the measure would be used, not the score used to determine shared savings. For each qualifying measure, CMS would determine whether there was a significant improvement or decline between the two performance years by applying a common standard statistical test. The awarding of bonus points would be based on an ACO's net improvement within a domain, and would be calculated by determining the total number of significantly improved measures and subtracting the total number of significantly declined measures. Up to two bonus points would be awarded on a sliding scale based on the ACO's net improvement for the domain to the total number of individual measures in the domain. Specifically, the bonus points, up to a maximum of two points, would be awarded in direct proportion to the ACO's net improvement for the domain to the total number of individual measures in the domain.

Background: Under section 1899 of the Act, CMS has established the Medicare Shared Savings program (Shared Savings Program) to facilitate coordination and cooperation among providers to improve the quality of care for Medicare FFS beneficiaries, and reduce the rate of growth in healthcare costs. Eligible groups of providers and suppliers, including physicians, hospitals, and other healthcare providers, may participate in the Shared Savings Program by forming or participating in an ACO. The final rule implementing the program appeared in the November 2, 2011, *Federal Register***.** Section 1899(b)(3)(C) of the Act requires the HHS Secretary to establish quality performance standards to assess the quality of care furnished by ACOs, and to seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for the purposes of assessing the quality of care. In the November 2011 final rule establishing the Shared Savings Program, CMS established the quality performance standards that ACOs must meet to be eligible to share in savings that are generated. Quality performance measures are submitted by ACOs through a CMS web interface, currently the GPRO web interface, calculated by CMS from internal and claims data, and collected through a patient and caregiver experience of care survey.

Value-Based Payment Modifier and Physician Feedback Program

Federal Register, pages 40492- 40516

Proposed Update: In the rule, CMS proposes policies to apply the value-based payment modifier (VM) to all physicians and groups of physicians and also nonphysician eligible professionals and to increase the amount of payment at risk. CMS also proposes to refine the methodologies used to determine its quality and cost composites and also to establish a corrections process for 2015. In the CY13 PFS final rule with comment period, CMS discussed the goals of the VM and also established that specific principles should govern the implementation of the VM. These principles focus on: measurement and alignment on physician and eligible professional choice, shared accountability, actionable information, and gradual implementation.

Group Size

In the CY13 PFS final rule with comment period, CMS stated that it would gradually phase in the VBP modifier in CY15 by first applying it to large groups, which it defined as groups of

physicians with 100 or more EPs. Under that final rule, the VBP modifier applies to groups of physicians with 10 or more EPs in CY16. CMS will identify groups of physicians that will be subject to the VBP modifier using the same procedures that it finalized in the CY13 PFS final rule with comment period. CMS believes this will continue its policy to phase in the VBP modifier by ensuring that the majority of physicians are covered in CY16 before it applies to all physicians in CY17.

In the CY14 PFS final rule with comment period, CMS continued its phase-in of the VM and adopted a policy to apply the VM in CY16 to groups of physicians with 10 or more eligible professionals. Since section 1848(p)(4)(B)(iii)(II) of the Act requires the HHS Secretary to apply the VM to items and services furnished under the PFS beginning not later than January 1, 2017, for all physicians and groups of physicians, CMS would to apply the VM in CY17 and each subsequent calendar year payment adjustment period to physicians in groups with two or more EPs, and to physicians who are solo practitioners. Performance on quality and cost measures in CY15 will be used to calculate the VM that is applied to items and services for which payment is made under the PFS during CY17. Table 55 of the proposed rule shows the number of groups, EPs, physicians, and nonphysician EPs in groups of various sizes based on an analysis of CY12 claims with a 90-day run-out period. CMS believes that it can validly and reliably apply a VM to groups with two or more EPs and to solo practitioners because it would be basing the quality of care composite on the PQRS measures selected, and reported on, by the groups (or the EPs in the groups) and the solo practitioners. Beginning in the CY14 performance period for the groups of physicians subject to the CY16 VM, CMS has permitted these groups for purposes of the VM to participate in the PQRS as a group under the GPRO or to have at least 50 percent of the EPs in the group participate in the PQRS as individuals (78 FR 74767 through 74768). As a result, physicians and other EPs in the group are able to report data on quality measures that reflect their own clinical practice.

Quality Tiering Model

The quality-tiering model compares the quality of care composite with the cost composite to determine the VM. In the CY14 MPF final rule, CMS adopted this model, under which, the quality of care composites scores are classified into high, average, and low quality of care categories based on whether they are statistically above, not different from, or below the mean quality composite score. The table below displays how CMS compares the quality of care composite classification with the cost composite classification to determine the VM adjustment.

TABLE 126—VALUE-BASED PAYMENT MODIFIER AMOUNTS FOR THE QUALITY-TIERING APPROACH

Quality/cost	Low cost	Average cost	High cost
High quality	+ 2.0x*	+ 1.0x*	+ 0.0%
Average quality	+ 1.0x*	+ 0.0%	−0.5%
Low quality	+ 0.0%	−0.5%	−1.0%

*Groups of physicians eligible for an additional +1.0x if reporting measures and average beneficiary risk score in the top 25 percent of all risk scores.

CMS will provide an upward payment adjustment for groups electing quality-tiering that are high performers and care for high risk beneficiaries.

Approach to Setting the VM Adjustment Based on PQRS Participation

In CY15, CMS will use a two-category approach to phase in the VM in 2015 to groups of physicians with 100 or more EPs. Groups in Category 1 may elect the quality-tiering methodology to calculate the VM to be applied to their PFS payments in CY15. Specifically,

CMS categorizes groups of physicians eligible for the VM into two categories:

Category 1 - includes groups of physicians that have:

a. self-nominated/registered for the PQRS as a group and reported at least one measure (also includes those groups that have self-nominated/registered and have met the satisfactory reporting criteria for the PQRS incentive payment)
b. elected the PQRS Administrative Claims option as a group.

- For those groups of physicians within Category 1 that have elected to have their VM based on quality-tiering and have either met the satisfactory reporting criteria for the PQRS incentive or chosen the PQRS Administrative Claims option:
    - CMS will use the performance rates on the quality measures reported through these reporting mechanisms (e.g., GPRO web-interface, CMS-qualified registry, or PQRS Administrative Claims option) and the three outcome measures to calculate their VM.
    - Quality-tiering could result in an upward, downward, or no payment adjustment.

- For those groups of physicians within Category 1 that have elected to have their VM based on quality-tiering, but did not meet the satisfactory reporting criteria for the PQRS incentive, CMS will use the group's performance on the PQRS Administrative Claims measures for quality-tiering. Although the group self-nominated/registered and reported at least one measure, CMS would not have sufficient quality information to construct a quality composite under the quality-tiering approach.
    - If the groups of physicians in Category 1 (both (a) and (b)) do not elect quality-tiering, then the VM will be 0.0 percent, meaning no payment adjustment will be applied to physicians in these groups for CY15.

Category 2 - includes those groups of physicians with 100 or more EPs that do not fall within either of the two subcategories (a) and (b) of Category 1 described above. The VM for these groups of physicians will be -1.0 percent in CY15.

In CY16, CMS will align the criteria for inclusion in Category 1 with the criteria for the CY16 PQRS payment adjustment. For the CY16 value-based payment modifier, Category 1 will include those groups of physicians that meet the criteria for satisfactory reporting of data on PQRS quality measures through the GPRO for the CY16 PQRS payment adjustment. It will also include those groups of physicians that do not register to participate in the PQRS as a group practice in CY14, and that have at least 50 percent of the their EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the CY16 PQRS payment adjustment or, in lieu of satisfactory reporting, for satisfactory participation in a PQRS QCDR for the CY16 PQRS payment adjustment. For a group of physicians that is subject to the CY16 value-based payment modifier to be included in Category 1, the criteria for satisfactory reporting (or the criteria for satisfactory participation, in the case of the 50 percent option) must be met during the CY14 performance period for the PQRS CY16 payment adjustment. Category 2 will include those groups of physicians that are subject to the CY16 value-based payment modifier and do not fall within Category 1.

Approach to Setting the VM Adjustment Based on PQRS Participation for CY17

CMS proposes to use a similar two-category approach for the CY17 VM based on participation in the PQRS by groups and solo practitioners. To continue to align the VM with the PQRS and accommodate the various ways in which EPs can participate in the PQRS, for purposes of the CY17 VM, CMS proposes that Category 1 would include those groups that meet the criteria for satisfactory reporting of data on PQRS quality measures via the GPRO (through use of the web-interface, EHR, or registry reporting mechanism, as proposed in section III.K of the proposed rule) for the CY17 PQRS payment adjustment. CMS also proposes to include in Category 1, groups that do not register to participate in the PQRS as a group practice participating in the PQRS GPRO in CY15, and that have at least 50 percent of the group's EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals (through the use of claims, EHR, or registry reporting mechanism) for the CY17 PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS qualified clinical data registry. Also included would be those solo practitioners that meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals (through the use of claims, registry, or EHR reporting mechanism) for the CY17 PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS qualified clinical data registry for the CY17 PQRS payment adjustment.

Category 2 would include those groups and solo practitioners that are subject to the CY17 VM and do not fall within Category 1. CMS would apply a -4.0 percent VM to groups with two or more eligible professionals and solo practitioners that fall in Category 2. In the event that the criteria that are finalized for the CY17 PQRS payment adjustment differ from what is proposed for the PQRS in the proposed rule, CMS intends to align the criteria for inclusion in Category 1 to the extent possible with the criteria that are ultimately established for the CY17 PQRS payment adjustment. In the CY14 MFPS final rule, CMS finalized that groups of physicians in Category 1 with between 10 and 99 eligible professionals would be held harmless from any downward adjustments derived from the quality tiering methodology for the CY16 VM. For the CY17 VM, CMS proposes to continue a similar phase-in of the quality-tiering based on the number of eligible professionals in the group. Accordingly, CMS propose that solo practitioners and groups with between 2 and 9 eligible professionals in Category 1 would be held harmless from any downward adjustments derived from the quality-tiering methodology for the CY17 VM.

Application of the VM to Physicians and Nonphysician Eligible Professionals

CMS established a policy in the CY13 PFS final rule to not apply the VM in CY15 and CY16 to groups of physicians that participate in the Shared Savings Program Accountable Care Organizations, the Pioneer ACO Model, the Comprehensive Primary Care (CPC) Initiative, or other initiatives. However, because Section 1848(p)(4)(B)(iii)(II) of the Act requires application of the VM beginning not later than January 1, 2017, to all physicians and groups of physicians, CMS proposing to apply the VM to all physicians in groups with two or more EPs and to solo practitioners who are physicians starting in CY17. In the proposed rule, CMS describes in detail how it proposes to apply the VM beginning in the CY17 payment adjustment period to the physicians and nonphysician EPs in groups, as well as those who are solo practitioners, participating in the Shared Savings Program Pioneer ACO Model, the Comprehensive Primary Care Initiative, or other similar Innovation Center models or CMS initiatives.

Payment Adjustment Amount

In the CY14 PFS final rule with comment period, CMS adopted a policy to apply a maximum downward adjustment of 2.0 percent for the CY16 VM for those groups of physicians with 10 or more EPs that are in Category 2, and for groups of physicians with 100 or more EPs that are in Category 1 and are classified as low quality/high cost groups. CMS received comments on the CY14 proposed rule suggesting that the payment adjustment under the VM must be of significant weight to drive physician behavior toward achieving high quality and low cost care and that the VM should represent a larger percentage of physician payments under the PFS that should be increased incrementally from 2.0 percent and subject to annual review. CMS agreed that the amount of payment at risk should be higher to incentivize physicians to provide high quality and low cost care. CMS also stated that its experience under PQRS has shown us that a 1.0 or 2.0 percent incentive payment has not produced widespread participation in the PQRS.

Thus, CMS believed that it needed to increase the amount of payment at risk for the CY16 VM to incentivize physicians and groups of physicians to report PQRS data, which will be used to calculate the VM. CMS proposes to increase the downward adjustment under the VM by doubling the amount of payment at risk from 2.0 percent in CY16 to 4.0 percent in CY17. Under the proposal, it would increase the maximum downward adjustment under the quality-tiering methodology in CY17 to -4.0 percent for groups and solo practitioners classified as low quality/high cost, and to set the adjustment to -2.0 percent for groups and solo practitioners classified as either low quality/average cost or average quality/high cost. CMS proposes to hold solo practitioners and groups with between two and nine EPs that are in Category 1 harmless from any downward adjustments under the quality-tiering methodology in CY17.

Also under the proposal, in CY17, the maximum upward adjustment under the quality-tiering methodology would be increased. CMS also proposes to increase in CY17 to +4.0x for groups and solo practitioners classified as high quality/low cost, and to set the adjustment to +2.0x for groups and solo practitioners classified as either average quality/low cost or high quality/average cost. CMS would continue to provide an additional upward payment adjustment of +1.0x to groups and solo practitioners that care for high-risk beneficiaries (as evidenced by the average Hepatocellular Carcinoma risk score of the attributed beneficiary population). Table 58 of the proposed rule displays the proposed quality-tiering payment adjustment amounts for CY17 (based on CY15 performance).

Performance Period

In the CY14 PFS final rule CMS adopted a policy that performance on quality and cost measures in CY15 will be used to calculate the VM that is applied to items and services for which payment is made under the PFS during CY17. Accordingly, CMS added a new paragraph (c) to § 414.1215 to indicate that the performance period is CY15 for VM adjustments made in the CY17 payment adjustment period.

Quality Measures

In the CY14 PFS final rule, CMS aligned its policies for the VM for CY16 with the PQRS group reporting mechanisms available to groups in CY14 and the PQRS reporting mechanisms available to individual EPs in CY14. As such, data submitted by individual EPs or groups for quality reporting purposes through any of the PQRS individual or group reporting mechanisms in CY14 will be used for calculating the quality composite under the quality-tiering approach for the VM for CY16.

CMS also established a policy to include three additional quality measures (outcome measures) for all groups of physicians subject to the VBPM:

- A composite of rates of potentially preventable hospital admissions for heart failure, chronic obstructive pulmonary disease, and diabetes
- A composite rate of potentially preventable hospital admissions for dehydration, urinary tract infections, and bacterial pneumonia
- Rates of an all-cause hospital readmissions measure

PQRS Reporting Mechanisms

CMS believes that it is important to continue to align the VM for CY17 with the requirements of the PQRS, because quality reporting is a necessary component of quality improvement. Accordingly, for purposes of the VM for CY17, CMS proposes to include all of the PQRS GPRO reporting mechanisms available to groups for the PQRS reporting periods in CY15 and all of the PQRS reporting mechanisms available to individual EPs for the PQRS reporting periods in CY15.

PQRS Quality Measures

CMS proposes to use all of the quality measures that are available to be reported under the various PQRS reporting mechanisms to calculate a group or solo practitioner's VM in CY17 to the extent that a group (or individual EPs in the group, in the case of the ''50 percent option'') or solo practitioner submits data on these measures. Groups with two or more EPs would be able to elect to include the patient experience of care measures collected through the PQRS CAHPS survey for CY15 in their VM for CY17. CMS proposes to continue to include the three outcome measures in the quality measures used for the VM in CY17. For groups that are assessed under the ''50 percent option'' for the CY17 VM, CMS proposes to calculate the group's performance rate for each measure reported by at least one EP in the group by combining the weighted average of the performance rates of those EPs.

While CMS finalized policies in the CY14 final rule that would allow groups assessed under the ''50 percent option'' to have data reported through a PQRS QCDR in CY14 used for the purposes of their CY16 VM to the extent performance data are available, CMS did not directly address the issue of how it would compute the national benchmarks for these measures. Benchmarks for the quality of care measures for the VM are the national mean of a measure's performance rate during the year prior to the performance period. In the CY13 PFS final rule, CMS finalized a policy that if a measure is new to the PQRS, it will be unable to calculate a benchmark, and performance on that measure will not be included in the quality composite. Therefore, under the proposed rule, it would apply that policy to measures reported through a PQRS QCDR that are new to PQRS. Performance on these measures would not be included in the quality composite for the VM because CMS would not be able to calculate benchmarks for them. This proposal would apply beginning with the measures reported through a PQRS QCDR in the CY14 performance period for the CY16 payment adjustment period.

Including the MSPB Measure

The Medicare Spending Per Beneficiary (MSPB) measure is included in the cost composite beginning with the CY16 VBPM, with a CY14 performance period. CMS will use the MSPB amount as the measure's performance rate rather than converting it to a ratio, as is done under the Hospital Inpatient Quality Reporting and Value-Based Purchasing Programs. The MSPB

measure will be added to the total per capita costs for all attributed beneficiaries domain and equally weighted with the total per capita cost measure. It will not be added to the total per capita costs for all attributed beneficiaries with specific conditions domain. CMS is finalizing the method under which an MSPB episode will be attributed to a single group of physicians that provides the plurality of Part B services during the index admission, for the purpose of calculating that group's MSPB measure rate. CMS is finalizing a minimum of 20 MSPB episodes for inclusion of the MSPB measure in a physician group's cost composite.

Quality Measures for the Shared Savings Program

Starting with the CY17 payment adjustment period, CMS is proposing to apply the VM to groups and solo practitioners participating in ACOs under the Shared Savings Program. To do so, it is proposing quality measures and benchmarks for use with these groups and solo practitioners and seeks public comment on these proposals. CMS describes these proposals in detail in the proposed rule.

Discussion Regarding Treatment of Hospital-Based Physicians

CMS is considering including or allowing groups that include hospital based physicians or solo practitioners who are hospital-based to elect the inclusion of Hospital VBP Program performance in their VM calculation in future years of the program. CMS is considering this potential policy to expand the performance data included for hospital-based physicians and to better align incentives for quality improvement and cost control across CMS programs. Such a policy would also address public comments the agency received on the CY14 PFS proposed rule, suggesting that the Hospital VBP Program total performance score for the hospital in which a specialist practices should be used in the VM. To identify groups or solo practitioners that would have Hospital VBP Program performance data in their VM, or allow such groups to elect its inclusion, CMS first has to identify who would have this option. Because the VM is applied at the Tax identification number (TIN) level, CMS believes that the election to include Hospital VBP Program data must also be made at the TIN level. CMS discusses the two methods for identifying which TINs represent hospital-based physicians and should therefore have Hospital VBP Program data included or have the option to elect its inclusion, the methodology required to determine which hospital or hospitals' performance would apply to a given TIN, and the process for incorporating that hospital's or hospitals' Total Performance Score(s) or some subset of it into the VM.

Background: Section 1848(p) of the Act requires CMS to establish a VBPM and apply it to specific physicians and groups of physicians the HHS Secretary determines appropriate starting January 1, 2015, and to all physicians and groups of physicians by January 1, 2017. On or after January 1, 2017, section 1848(p)(7) of the Act provides the HH Secretary discretion to apply the VM to EPs as defined in section 1848(k)(3)(B) of the Act. Section 1848(p)(4)(C) of the Act requires the VM to be budget neutral. In this rule, CMS is proposing policies to apply the VM to all physicians and groups of physicians, and also nonphysician EPs, and to increase the amount of payment at risk. CMS is also proposing to refine the methodologies used to determine its quality and cost composites and also to establish a corrections process for 2015.

Physician Feedback Program

CMS is required to provide confidential reports to physicians who measure the resources involved in furnishing care to Medicare FFS beneficiaries. CMS is also authorized to include information on the quality of care furnished to Medicare FFS beneficiaries. In the fall of

2013, CMS provided Quality and Resources Use Reports (QRURs) to certain physicians and groups based on CY12 data. CMS intends to make reports based on CY13 data available in the fall of 2014. These reports provide physicians and groups of physicians with comparative performance data (both quality and resource use) that can be used to improve quality and coordinate care furnished to Medicare FFS beneficiaries. Additionally, in June 2013, and June 2014, CMS provided supplemental QRURs to group report recipients that featured episode-based costs of care.

Future Plans for the Physician Feedback Reports

CMS will continue to develop and refine the annual QRURs in an iterative manner. As it has done in previous years, it will seek to further improve the reports by welcoming suggestions from recipients, specialty societies, professional associations, and others. In the late summer of 2014, CMS plans to disseminate the QRURs based on CY13 data to all physicians (that is, TINs of any size) even though groups with fewer than 100 EPs will not be subject to the VM in CY15. Additionally, the VM will not apply to any group that participated in the Shared Saving Program, the Pioneer ACO model, or the Comprehensive Primary Care Initiative during the performance period (CY13). These reports will contain performance on the quality and cost measures used to score the composites and additional information to help physicians coordinate care and improve the quality of care furnished. Improvements to this year's reports include:

- Additional supplementary information on the specialty adjusted benchmarks;
- Inclusion of the individual PQRS measures for informational purposes for individual EPs reporting PQRS measures on their own;
- Enhanced drill down tables; and a dashboard with key performance measures.

The reports will be based on the VM policies that were finalized in the CY13 PFS final rule, and that will affect physician payment starting January 1, 2015. After the reports are released CMS will again solicit feedback from physicians and continue to work with its partners to improve them.

Physician Feedback and Quality Resource Use Reports

CMS plans to disseminate QRURs based on CY13 data to all groups of physicians and physicians who are solo practitioners. These QRURs will contain performance information on the quality and cost measures used to calculate the quality and cost composites of the VM and will show how all tax identification numbers would fare under the policies established for the VM for the CY 2015 payment adjustment period.

More Information

The final rule was published in the July 11, 2014, *Federal Register*. Additional information regarding the MPFS is available on the CMS website.