

## **Summary of the Proposed Medicare Physician Fee Schedule Rule for CY 2015**

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## **Resource-Based Practice Expense (PE) Relative Value Units (RVUs)**

In prior years CMS has expressed concerns about the accuracy of the information they use in the development of PE RVUs. The particular concern regarding the direct PE inputs is inaccurate resource data, which includes both the procedural time assumptions and the individual supplies and equipment. It is also concerning to CMS that the allocation of the indirect PE is based on information collected several years ago and thus is potentially outdated. In the CY 2014 proposed rule, CMS sought to mitigate the impact of some of the potentially problematic data by proposing a change to the PE methodology. The idea was to use the Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Center (ASC) payment rates as a point of comparison in establishing the PE RVUs for physician fee schedule (PFS) services. This approach would allow the agency to limit the non-facility PE RVUs for individual codes, as this would eliminate the non-facility PFS payment amount from exceeding the total combined amount Medicare would pay for the same code in the facility setting. Due to a number of concerns expressed last year during the comment period by ACP and others, CMS did not finalize their proposal to use OPPS and ASC rates to ensure that PFS rates are based on accurate cost assumptions; however, CMS is continuing to explore alternative approaches to establishing more valid PE RVUs. CMS has noted their continued belief that the hospital cost data (i.e., OPPS and ASC) can in some way be used in PE RVU methodology to ensure its validity. In the current proposed rule, CMS states “the routinely updated, auditable resource cost information submitted contemporaneously by a wide array of providers across the country is a valid reflection of “relative” resources and could be useful to supplement the resource cost information developed under our current methodology.” **Therefore, CMS is seeking comments regarding the possible uses of the Medicare hospital outpatient cost data in potential revisions of the PFS PE methodology.**

Related to the above, CMS is also interested in the growing trend of hospital acquisition of physician practices with a focus on the validity of the resource data as more physician practices become hospital-based. The current PE methodology primarily distinguishes between the resources involved in furnishing services in two sites of service, the facility and non-facility; however, as more physician practices become hospital-based, it becomes more challenging to recognize which PE costs are incurred by the physician and which are incurred by the hospital, as well as whether the current methodology adequately accounts for the typical resource costs given these relationships. Therefore, **CMS is proposing to collect data on the type and frequency of services furnished in off-campus provider based departments, through the use of a HCPCS modifier to be reported with every code for physician and hospital services furnished in an off-campus, provider-based department of a hospital on both the 1500 and the UB-04.**

## **Potentially Misvalued Services Under the Physician Fee Schedule**

### **Abdominal Aortic Aneurysm Ultrasound Screening - G0389**

In 2007 Medicare created a new HCPCS code G0389 (*Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening*), to pay for abdominal aortic aneurysm ultrasound. The RVUs of 2.96 for code G0389 were established at the same time as the CPT code 76775 (*Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), B-scan and/or real time with image documentation; limited*) for the diagnostic test. Based on the RUC recommendation in CY 2014 CMS proposed to change (remove from the practice expense) the ultrasound room and replace it with a portable ultrasound machine in the direct practice expense input for CPT code 76775. This change brought about a considerable reduction to HCPCS code G0389 since this code's RVUs were cross walked directly from CPT 76775. Subsequent to the CY 2014 proposal and finalization, CMS received comments regarding this change; for HCPCS code G0389 the type of equipment is different, the time to perform the service is greater, and the specialty performing the service is different from CPT code 76775. **CMS is seeking comments on the appropriate inputs to develop RVUs for HCPCS code G0389 and therefore proposing to put this code on the potentially misvalued list.** (According to the claims data this code is performed 40.26% of the time by IM)

### **Obesity Behavioral Group Counseling – GXXX2 and GXXX3**

Intensive Behavioral Therapy for Obesity has been a preventive service for patients since 2011 identified by HCPCS code G0447 (*Face-to-face behavioral counseling for obesity, 15 minutes*). Code G0447 is for individual counsel and payment; however, this type of counseling sometimes occurs in group settings. Therefore CMS is creating two new HCPCS codes for reporting and payment of obesity counseling in group settings GXXX2 (*Face-to-face behavioral counseling for obesity, group (2- 4), 30 minutes*) and GXXX3 (*Face-to-face behavioral counseling for obesity, group (5-10), 30 minutes*). The work and intensity for these new codes are believed to be the same as for code G0447 which is a 15-minute code with a work RVU of 0.45. **Therefore, CMS is proposing a work RVU of 0.90 for a 30 minute session to account for the longer time in the group codes. These codes will be billed on a per patient basis; therefore, the proposal describes a work RVU of 0.23 with a work time of 8 minutes for GXXX2 and a work RVU of 0.10 with a work time of 3 minutes for GXXX3. The same logic will be used for the direct practice expense and the malpractice risk factor will be cross-walked from code G0447.** (According to the claims data this code is performed 59.92% of the time by IM)

### **Improving the Valuation and Coding of the Surgical Global Package**

Surgical global packages have always been a part of the PFS. The 0-day global codes include the surgical procedure and the pre-operative and post-operative physicians' services on the day of the procedure, including visits related to the service. The 10-day global codes include these services and, in addition, visits related to the procedure during the 10 days following the procedure. The 90-day global codes include the same services as the 0-day global codes plus the pre-operative services furnished one day prior to the procedure and post-operative services during the 90 days immediately following the day of the procedure.

Global payments are supported by CMS as evidenced by their use in the hospital inpatient and outpatient prospective payment systems. However, in the proposed rule, CMS outlines a number of frequent and noteworthy concerns about the accuracy of the 10- and 90-day surgical global codes. The primary issue is that these global surgical codes were established several decades ago and, despite changes in surgical practices, the basic structures of the global surgery packages are the same as the packages that existed prior to the creation of the resource-based relative value system in 1992. Different from other typical models of bundled payments, the payment rates for the global surgery packages are not updated regularly based on any reporting of the actual costs of patient care. Additionally, there are no separate PFS values established for the procedures or the follow-up care that are included within the package; therefore, payment for the PFS global packages relies on valuing the combined services together.

**CMS is proposing to transition all 10- and 90-day global codes to 0-day global codes; 10-day global codes transitioning in CY 2017 and 90-day global codes transitioning in CY 2018.**

### **New Chronic Care Management (CCM) Code**

CMS remains committed to CCM. Much of the scope of service for this code was finalized in the CY 2014 final rule such as:

- Patient eligibility for chronic care management services - patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
- Chronic care management service may be billed for periods in which the medical needs of the patient require establishing, implementing, revising, or monitoring the care plan, assuming all other billing requirements are met.
- GXXX1 and any of CPT 99495–99496, HCPCS G0181–G0182, or CPT 90951–90970 cannot be billed during the same 30-day period; nor can GXXX1 be billed by multiple practitioners for the same time period.

The current proposed rule now serves to outline CMS' plans for this new G code. Chronic care management services as described in this code must be furnished to patients for 20 minutes or more during a 30 day period. The work RVUs for the CCM code GXXX1 is proposed for 0.61 down from the 1.0 work RVU recommended by the Relative Value Update Committee (RUC) for proposed CPT code 99490X; however, the CPT code proposal was not accepted by CMS in the proposed rule. The estimated payment for code GXXX1 is \$43.67. Those billing the proposed code must meet the following service requirements:

- ✓ CCM is defined by CMS as “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.”
- ✓ GXXX1; 20 minutes or more; per 30 days
- ✓ A clinician who meets the scope of service requirements to bill for chronic care management services may initiate services with an eligible beneficiary as a part of an Annual Wellness Visit (AWV), an Initial Preventive Physical Exam (IPPE), or a comprehensive E/M visit. Along with clinical benefits, CMS believes that the proposed approach of initiating CCM services via AWV or IPPE provides an administrative benefit. It allows the agency to know which clinician the beneficiary has chosen to furnish chronic care management services, therefore minimizing the chances that multiple clinicians would be providing the same service to the same patient.

The clinician providing the service requirements must:

- Provide 24/7 access to the patient in order to address his/her acute chronic care needs. The patient would be given a means to contact the practice's clinicians in a timely manner. Members of the chronic care team must have access to the patient's full electronic medical record, even when the office itself is closed;
- Provide continuity of care with a designated clinician or member of the care team with whom the patient would be able to obtain successive routine appointments;
- Conduct a systematic assessment of the patient's medical, functional, and psychosocial needs;
- Undertake system-based approaches to ensure timely receipt of all recommended preventive care services;

- Conduct medication reconciliation with review of adherence and potential interactions;
- Provide oversight of patient self-management of medications;
- Develop a comprehensive, patient-centered care plan written in consultation with the patient and with other key practitioners who are treating the patient, based on physical, mental, cognitive, psychosocial, functional and environmental assessment and reassessment and an inventory of resources and supports, assuring that the care provided is harmonized with the patient's wishes and values;
- Manage care transitions within health care, including referrals to other clinicians, visits that follow an emergency department visit, and visits following discharge from hospitals and skilled nursing facilities;
- Coordinate with home- and community-based clinical services; and
- Provide enhanced opportunities for the patient to communicate with the clinician, to include not only the telephone but also secure messaging, Internet communication or other same-time consultation methods.

The most notable aspects of the proposal are the following:

- **CMS is proposing to remove the requirement that was outlined in the 2014 final rule that the clinical staff has to be a direct hire of the clinician or the practice.**
- **CMS is further proposing to remove the requirement that clinical staff time under general supervision would only be counted if provided outside of the practice's normal business hours. This will allow clinical staff time to be counted at any time as long it meets the general supervision requirements.**
- **CMS is proposing CCM services be performed with the use of EHR or other health IT information exchange platform. At the very least the EHR must meet the standard of data capture of demographics, problem lists, medications, and other elements required to create and electronic summary record. The electronic data must be accessible to all practitioners providing care during and after normal business hours.** This proposal would require a physician to utilize an electronic health record certified at least to the criteria identified in the 2014 edition certified electronic health record technology (CEHRT) for EHRs. CMS would like EHRs to be capable of dealing with care plans as

structured data, with all participants in care, including the patient, being able to contribute and share patient centered care plans. The 2014 EHR criteria includes but is not limited to the following elements:

- Enables secure messaging between a provider and a patient;
  - Permits a patient to securely view, download, and electronically transmit his/her health information, including the ability to track the use of these patient capabilities;
  - Transport standards for the exchange of transitions of care/referral summaries as well as transmission of patient summaries as part of the view, download, and transmit to a third party certification criterion;
  - Improving the exchange of laboratory test results between hospitals and ambulatory providers as well as a certification criterion focused on the receipt of laboratory test results which references a common interface standard for ambulatory EHR technology;
  - Improve EHR technology's ability to report information to public health agencies, including reporting cancer case information to cancer registries;
  - Electronic data capture, calculation and enabling electronic submission of CQM data to CMS.
- Another proposal in the rule is related to the Multi-Payer Advanced Primary Care Demonstration and the Comprehensive Primary Care Initiative. **CMS is proposing that clinicians participating in such models would not be able to bill for CCM as this would cause duplicative payments (because of the overlap in service payments).** Although a clinician would not be able to use the CCM code for patients included in the demonstration models, they may use the CCM code for other patients that meet the CCM criteria even though this may be a limited number.

### **Valuing New, Revised and Potentially Misvalued Codes**

CMS currently establishes interim values for new, revised, and potentially misvalued codes in its *final* rule (as opposed to its proposed rule), due to the incongruity between the PFS rulemaking cycle and the release of codes by the AMA CPT Editorial Panel and the RUC review process. The agency has previously stated that this policy is necessary because CMS did not receive the codes in time to include them in its PFS proposed rule. Initially this only affected new and revised codes and the revaluation of existing codes was done through the five-year review process. Under the five-year review process,

revisions in RVUs were proposed in the proposed rule and finalized in the final rule. Starting in CY 2009, CMS and the RUC began identifying potentially misvalued codes on an ongoing basis. This has led to an increase in the volume of new and revised codes which has led to an increase in payment changes each year.

In an effort to address this, CMS proposes to modify this process by proposing that all changes in the work and Malpractice (MP) RVUs and the direct PE inputs for new, revised and potentially misvalued services under the PFS be included in the **proposed rule**, beginning with the PFS proposed rule for CY 2016. CMS would include proposed values for all new, revised, and potentially misvalued codes for which they have complete RUC recommendations by January 15<sup>th</sup> of the preceding year (which would allow sufficient time for stakeholders to be made aware and respond to proposed values).

The AMA has been working with CMS on establishing a timeframe that would allow a much greater percentage of codes to be addressed in the proposed rule.

If CMS goes through with its proposal to address code values in its proposed rule, they would eliminate the refinement panel process; which is the process adopted by CMS to assist them in reviewing the public comments on CPT codes with interim final work RVUs for a year and in developing final values for the subsequent year.

### **Removal of Employment Requirements for Services Furnished “Incident to” Rural Health Clinics (RHC) and Federally Qualified Health Center (FQHC) Visits**

Current regulations state that services furnished “incident to” an RHC or FQHC visit must be furnished by an employee of the RHC or FQHC. However, nurses, medical assistants, and other auxiliary personnel cannot bill Medicare directly and receive payment; rather they can only be remunerated when furnishing services to Medicare patients in an “incident to” capacity. To provide RHCs and FQHCs with as much flexibility as possible with their staffing needs, CMS proposes to remove this requirement and allow nurses, medical assistants, and other auxiliary personnel to furnish “incident to” services under contract in RHCs and FQHCs.

### **Medicare Telehealth Services**

In its current proposed rule, CMS is proposing to add the following services to the list of services that can be furnished to Medicare beneficiaries under the telehealth benefit:

- CPT codes 90845 (Psychoanalysis); 90846 (family psychotherapy (without the patient present)); and 90847 (family psychotherapy (conjoint psychotherapy) (with patient present));

- CPT codes 99354 (prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (list separately in addition to code for office or other outpatient evaluation and management service); and, 99355 (prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service); each additional 30 minutes (list separately in addition to code for prolonged service); and,
- HCPCS codes G0438 (annual wellness visit); includes a personalized prevention plan of service (pps), initial visit; and, G0439 (annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit).

## **Regulatory Impact Analysis**

For this proposed rule to maintain budget neutrality for the proposed policies, the conversion factor (CF) for the time period of January 1, 2015 to March 31, 2015 will be \$35.7977. If this CF holds throughout the year the impact for internal medicine is a positive 2%.

## **Reports of Payments or Other Transfers of Value to Covered Recipients (Proposed Changes to the Open Payment Program)**

The current Open Payments regulations include an exception to the reporting requirements for specified continuing education arrangements. More specifically, Section 403.904(g)(1) of the current open payments regulation states that payments or other transfers of value provided as compensation for speaking at a continuing education program need not be reported if the following three conditions are met:

- The event at which the covered recipient is speaking must meet the accreditation or certification requirements and standards for continuing education for one of the following organizations: the Accreditation Council for Continuing Medical Education (ACCME); the American Academy of Family Physicians (AAFP); the American Dental Association's Continuing Education Recognition Program (ADA CERP); the American Medical Association (AMA); or the American Osteopathic Association (AOA);
- The applicable manufacturer does not pay the covered recipient speaker directly; and
- The applicable manufacturer does not select the covered recipient speaker or provide the third party (such as a continuing education vendor) with a distinct, identifiable set of individuals to be considered as speakers for the continuing education program.

CMS, under this proposed rule, intends to **remove this continuing education exception provision** in its entirety. This is being proposed for several reasons including: to prevent the unintended appearance of endorsing certain specific continuing education sponsors above others, to increase consistency in reporting, and to eliminate the redundancy of this exception with another

exclusion in the regulations (Section 403.904(i)1), which excludes indirect payments or other transfers of value where the applicable manufacturer is “unaware” of, that is, “does not know,” the identity of the covered recipient. Under this proposed change, when an applicable manufacturer or applicable GPO provides funding to a continuing education provider, but does not either select or pay the covered recipient speaker directly, or provide the continuing education provider with a distinct, identifiable set of covered recipients to be considered as speakers for the continuing education program, CMS will consider those payments to be excluded from reporting.

CMS is also proposing several additional minor changes to the program including;

- requiring the reporting of the marketed name of the transfer of value-related drug, device, biological, or medical supply, unless the payment or other transfer of value is not related to a particular drug, device, biological or medical supply; and
- requiring the reporting of stock, stock option, or any other options as distinct categories.

### **Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models**

CMS is planning to exercise their authority under the Innovation Center legislation and regulations, to obtain access to identifiable data from patients, physicians and other health professionals, and suppliers that are participating in an Innovation Center program. This includes **both public and private sector participants**. Identification of data at the individual level is necessary for a variety of purposes, including the construction of control groups and to effectively evaluate such factors as patient outcomes, clinical quality, adverse effects, access, utilization, patient and clinician satisfaction, sustainability, and total cost of care. If finalized, this regulation will provide clear legal authority for HIPAA Covered Entities to disclose any required protected health information. Identifiable data submitted by entities participating in the testing of models by the Innovation Center will meet CMS Acceptable Risks Safe Guards (ARS) guidelines. When data are expected to be exchanged over the internet, such exchange will also meet all E-Gov requirements. In accordance with the requirements of the Privacy Act of 1974, these data will also be covered under a CMS established system of records (System No. 09-70-0591), which serves as the Master system for all demonstrations, evaluations, and research studies administered by the Innovation Center. These data will be stored until the evaluation is complete and all necessary policy deliberations have been finalized.

### **Medicare Shared Savings Program**

CMS is proposing the following changes to the Medicare Shared Savings Program: to modify the current set of quality measures (including a request for comment on potential future quality performance measures); to modify the current quality performance benchmark methodology, including the timeframe

between updates to the benchmarks; and to establish an additional incentive to reward ACO quality improvement each year. These changes are discussed in greater detail below.

- Modifications to the current set of quality measures: CMS proposes to change the current set of 33 quality measures in order to enhance ACO quality reporting, better reflect clinical practice guidelines, streamline measures reporting, and enhance alignment with PQRS and the EHR Incentive Program. Therefore, the proposed rule adds 12 new measures and retires 8 measures. The proposed new set of 37 measures is not anticipated to increase the reporting burden on ACOs. The increased number of measures is accounted for and mitigated by measures that would be automatically calculated by CMS using administrative claims data or from a patient survey. This means that the total number of measures that the ACO would need to directly report through the CMS website interface would actually decrease by one (to 32), and some redundancy in measures reported would be removed. All new measures will be phased in over the 3-year ACO contract period, thus only requiring complete and accurate reporting during the first year of the 3-year contract period. CMS is also proposing to rename the current 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 CAD composites.
- Request for comments on potential future quality performance measures: In the proposed rule, CMS requests comments on further potential modifications to the quality measurement set, including the addition of measures reflecting caregiver experience of care, and issues specific to the frail elderly, public health, and health care service utilization. They also seek comment on how to better align the ACO measures with those to be used under the Value-based Modifier program, which will be applied to all physician and non-physician eligible professionals participating in the Shared Saving Program by 2017.
- Modifications to benchmark methodology including the timeframe between updates to the quality performance benchmarks: CMS is proposing the following changes to the quality performance benchmarks:
  - Modify the methodology used for “topped out” measures in which most participating organizations receive near perfect scores in order to decrease a bias that favors smaller practices.
  - Define that ACOs that enter into a second 3-year contract would continue to be assessed on the quality performance standard that would otherwise apply to an ACO if it were in the third performance year of the first agreement period.
  - Update benchmarks every 2 years rather than yearly to provide increased stability.
- Rewarding Quality Improvement: CMS is proposing to enhance its current quality scoring strategy by explicitly recognizing and rewarding ACOs that make year-to-year improvements in their quality performance

scores on the individual performance measures. The proposed approach, derived partially from a methodology used within the Medicare Advantage program, would allow for the awarding of bonus points for quality improvement to each of the existing four quality measure domains. It is believed that this additional recognition of improvement will encourage ACOs to continue to improve quality for their patient populations over time, in addition to maintaining existing high quality levels.

The proposed rule also includes several technical corrections to the current regulations.

## **Physician Compare**

This section of the proposed rule continues the phased in approach to developing the Physician Compare website, which includes information on physicians and eligible professionals (EPs) enrolled in the Medicare program. CMS proposes to make a broader set of quality measures available for publication on the website. Specific proposals include:

- In 2015, publicly report 20 of the 2013 PQRS individual measures collected through a Registry, EHR, or claims, which mirrors the sub-set of 20 PQRS measures finalized for 2014 public reporting.
- In 2016, include an indicator (check mark) for satisfactory reporters under PQRS and PQRS GPRO, participants in the EHR Incentive Program, and EPs who report the PQRS Cardiovascular Prevention measures group in support of Million Hearts (based on data collection in 2015).
- In 2016, publicly report all 2015 PQRS GPRO measures reported via the web interface, EHR, and Registry for group practices of 2 or more EPs and all measures reported by ACOs with a minimum sample size of 20 patients. All measures would be available for download, and a select group of measures would be included on the webpage. These measures would be selected after CMS data analysis and working with consumer groups to identify meaningful measures for consumers.
- In 2016, publicly report 2015 CAHPS for PQRS for groups of 2 or more EPs and for ACO's who meet the specified sample size requirements.
- In 2016, publicly report all 2015 PQRS measures for individual EPs collected through a Registry, EHR, or claims. Also report available data from qualified clinical data registries at the individual level or aggregated to a higher level of the QCDR's choosing.

CMS proposes that all measures publicly reported must meet the public reporting criteria of a minimum sample size of 20 patients. In addition, CMS proposes to include an indicator of which reporting mechanism was used and only measures deemed statistically comparable would be included on the site. In addition, CMS proposes to publicly report all measures submitted and reviewed and found to be statistically valid and reliable in the Physician Compare downloadable file.

Group practices and individuals 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.

CMS also is considering creating composites using 2015 data and publishing composite scores in 2016 by grouping measures based on the PQRS GPRO measure groups, if technically feasible. These groups could include Care Coordination/Patient Safety (CARE) measures, Coronary Artery Disease (CAD) Disease Module, Diabetes Mellitus (DM) Disease Module, and Preventive (PREV) Care measures. Consumer organizations have requested this type of information as a way for patients to better understand quality measure data. CMS plans to analyze the data to determine if this is feasible, but requests feedback on this approach.

CMS also seeks comment on including specialty society measures on Physician Compare. For example, CMS seeks comment on the option of linking from Physician Compare to specialty society websites that publish non-PQRS measures.

## **Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System**

CMS continues to focus on aligning requirements with other quality reporting programs, such as Medicare EHR Incentive Program, Physician Value-Based Payment Modifier, and the Medicare Shared Savings Program. As previously established, eligible professionals (EPs) and groups that do not report in 2015 will receive a -2.0% payment penalty in 2017. The current proposals for avoiding the 2017 PQRS payment penalty are as follows:

### *Individual EP reporting*

- Individuals reporting via claims and registry would report at least 9 measures, covering at least 3 of the National Quality Strategy (NQS) domains AND report each measure for at least 50% of the EPs Medicare Part B FFS patients seen during the reporting period to which the measure applies.
- CMS is also proposing a new requirement that if an EP sees at least 1 Medicare patient in a face to face encounter, they would report on at least 2 cross-cutting measures from the set specified in Table 21.
- Individuals reporting via CEHRT would report 9 measures covering at least 3 of the NQS domains.
- For measure groups, individuals would need to report at least 1 measures group AND report each measures group for at least 20 patients, the majority of which must be Medicare patients.
- Qualified Clinical Data Registry (QCDR) participating EPs would report at least 9 measures covering at least 3 NQS domains and report each measure for 50% of the EP's patients. Of these measures, at least 3 must be outcome measures.

*Group Practice Reporting Option (GPRO):* CMS is proposing to change the deadline by which a group practice must register to participate in the GPRO to June 30 (instead of Sept 30). Additionally:

- Group practices of 25 or more using the web interface would have to report on 248 patients. (This is an increase for groups 25-99, but a decrease for groups 100+.)
- Reporting via qualified registry: all groups would be required to report at least 9 measures covering at least 3 NQS domains.
- CMS is also proposing a new requirement that if an EP sees at least 1 Medicare patient in a face to face encounter, they would report on at least 2 cross-cutting measures from the set specified in Table 21.
- EHR Reporting: report 9 measures covering at least 3 of the NQS domains.
- CMS is proposing to require reporting of CAHPS for PQRS for group practices of 100 or more EPs, and that it be optional for groups of 2-99 EPs. CMS is also proposing to require that beginning with the reporting period for 2018 PQRS payment adjustment, groups comprised of 25 or more EPs that are participating in GPRO report and pay for the collection of CAHPS for PQRS survey measures.

The CMS proposals outlined above are largely in line with the 2014 PQRS payment incentive reporting requirements. In general, the 2014 requirements to avoid the 2016 penalty were lower than the current proposal for the 2015 requirements (to avoid the 2017 penalty). Most methods required EPs or groups to report 3 measures in at least 1 NQS domain. Another notable potential change is the proposed requirement that if an EP sees at least 1 Medicare patient in a face to face encounter, they would report on at least 2 cross-cutting measures from the set specified in Table 21 (on page 308 of proposed rule).

## **Value-Based Payment Modifier and Physician Feedback Program**

CMS is proposing to apply the value modifier (VM) to all physicians and groups of physicians and also non-physician eligible professionals (EPs) and to increase the amount of payment at risk (from 2% to 4.0%) in CY 2017 (based on 2015 reporting data) and each subsequent calendar year payment adjustment period. This is in line with the requirements of the Affordable Care Act (ACA), which requires that the VM be applied to all physicians starting in 2017 and gives the Secretary discretion to apply the VM to other EPs. Physicians and non-physician EPs would be subject to the same VM policies established in this and subsequent rule making. CMS believes that this approach supports their goal of fostering shared accountability and high value care for individual patients.

As in previous years of the value based payment (VBP) program, CMS proposes to use a similar 2 category approach based on participation in PQRS. Category

1 would include groups that meet the criteria for satisfactory reporting of data on PQRS during 2015 via GPRO and groups that have at least 50% of their EPs meet the criteria for satisfactory reporting of data on PQRS as individual reporters, or in lieu of satisfactory reporting, participate in a PQRS qualified clinical data registry. Category 1 would also include solo practitioners that meet the criteria for satisfactory reporting or, in lieu of satisfactory reporting, participate in a PQRS qualified clinical data registry. Category 2 would include all other groups or solo practitioners and would be subject to a -4.0% adjustment in 2017 (based on performance in 2015). This would be in addition to the -2% under the PQRS reporting requirements.

In addition, CMS proposes to make quality-tiering mandatory for groups and solo practitioners within Category 1 for CY 2017 (based on 2015 data). Groups with 2-9 EPs and solo practitioners would be held harmless from downward adjustment and would only be subject to neutral or upwards adjustment, as this is their first year in the program. Groups with 10 or more EPs would be subject to upward, neutral, or downward adjustments determined under the quality-tiering methodology. Based on analysis from CY 2012 claims, CMS estimates that approximately 6 percent of all EPs are in a Category 1 TIN that would be classified in tiers that would earn an upward adjustment, approximately 11 percent would receive downward adjustment, and 83 percent would receive no payment adjustment. CMS believes that this suggests that their current methodology appropriately identifies the outliers on both ends of high and low performers.

CMS is also proposing to apply the VM to physicians and non-physician eligible professionals participating in the Shared Savings Program, the Pioneer ACO Model, the CPC Initiative, or other similar CMMI or CMS initiatives starting in CY 2017.

### **Electronic Health Record Incentive Program**

Several problems with EHR-based reporting of Clinical Quality Measures (CQMs) have been identified. CMS proposes several changes to address the problems.

1. Formerly, EPs were required to report using the latest version of e-measures and an EHR system certified for these latest versions of the particular measures. CMS agrees that this additional certification requirement is unnecessarily burdensome. For 2015, EPs would not be required to ensure that their CEHRT products are recertified to the most recent version of the e-measures. However, EPs must still report the most recent versions of the e-measures, even though their EHR systems may not be certified to report the most recent version of the e-measures.
2. If an error is discovered in the most recent version of an e-measure, CMS will revert to the previous version as the one required for reporting.
3. Regarding a specific measure, CMS140v2, Breast Cancer Hormonal Therapy for Stage IC–IIIC Estrogen Receptor/Progesterone Receptor

(ER/PR) Positive Breast Cancer (NQF 0387), an error has been discovered in the June 2013 version of the measure. Those EPs reporting on this measure in 2014 should use the December 2012 version of the measure, and EPs reporting on the measure in 2015 will use a new, recently corrected version.

4. For EPs who are part of the Innovation Center's Comprehensive Primary Care (CPC) initiative, an option is proposed that will allow them to report CQMs individually if their practice is unsuccessful in reporting as a group. Also, CPC practices are only required to report on measures from two domains rather than the three domain requirement that applies to all other EPs.