



ACP SUMMARY OF THE 2015 MEDICARE PHYSICIAN FEE SCHEDULE CHANGES

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Conversion Factor

The calendar year (CY) 2015 monetary conversion factor set by the final rule is \$35.80. This will be in effect from January 1 to March 31, 2015 at which time it will decrease 21.2 percent unless Congress acts.

Specialty Impacts for Internal Medicine

The specialty impact table is included below. For internal medicine and its subspecialties, the overall changes are:

SPECIALTY	COMBINED IMPACTS OF FEE SCHEDULE CHANGES (does not include conversion factor)
Internal Medicine	1%
Allergy & Immunology	0%
Cardiology	0%
Critical Care	0%
Endocrinology	0%
Gastroenterology	0%
Hematology/Oncology	1%
Infectious Disease	1%
Nephrology	0%
Neurology	0%
Pulmonary Disease	0%
Rheumatology	-1%

Chronic Care Management

Medicare continues to emphasize primary care by making payment for chronic care management (CCM) services—non-face-to-face services to Medicare beneficiaries who have multiple, significant, chronic conditions (two or more)—beginning in 2015. Chronic care management services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management.

CMS has established a payment rate of \$42.60 for CCM that can be billed up to once per month per qualified patient. Rather than create a new G code as proposed, CMS is using the new CPT code 99490, with the following description: *Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.*

In the final rule, CMS made a number of changes ACP had sought with regards to this code. These included:

- Finalizing their plan to provide payment to clinicians for the critically important non-face-to-face work involved in helping patients manage multiple chronic conditions—something the College has been calling on CMS to pay for over a number of years.
- Finalizing their proposal to allow greater flexibility in the supervision of clinical staff providing CCM services. The proposed application of the “incident to” supervision rules were widely supported by the ACP and several other commenters.
- Adopting a CPT code (99490) rather than a G code for the chronic care management services, which is something ACP had asked for and expects will allow for broader adoption of this code by clinicians and payers.
- Making some improvements in the requirements for electronic health records (EHRs) by not requiring a 2014 certified EHR system but rather allowing the use of a 2011 or 2014 certified system.
- Making some moderate improvements to the electronic care plan requirements. And while these did not go as far as ACP would have liked—the details of our concerns are outlined below—ACP will be working to clarify with CMS exactly what will be needed for practices to successfully implement this code, comply with the care plan requirements, and be paid for this service.

Even in light of CMS’ receptiveness to ACP’s recommendations as outlined above, the College still has concerns about the CCM code, specifically:

1. The payment amount for the CCM code, which is well below the Relative Value Scale Update Committee (RUC) recommended value.

The RUC recommended a value of 1.0 RVU for CPT code 99490, which would have resulted in a payment rate of nearly \$80. However, CMS ultimately finalized an RVU of 0.61 with 20 minutes of clinical staff time, which translates to a payment rate of \$42.60. While this payment rate may reduce expenditure growth, ACP remains concerned about whether it will encourage long-term investments in the care management services for patients with multiple chronic conditions.

2. The use of care plans according to the rule may require some practices to invest in additional health information technology (HIT) to ensure that they will have the needed care plan management and communication capabilities.

This investment in additional HIT could be a significant expense for practices. Further, the care plan requirements as outlined by CMS may result in some clinicians having to both enter and maintain duplicative information in multiple systems or split what should be a single clinical data repository into multiple disconnected systems. ACP’s specific concerns with the CCM electronic care plan requirements, as outlined in our comment letter on the proposed rule, that still have not been addressed include:

- Care plan data requirements, as laid out by CMS, are not fully supported by any currently existing EHRs. These include the following:
 - CMS notes that a full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination, and ongoing clinical care—and therefore the rule calls for structured recording of demographics, problems, medications, medication allergies, and creation of structured clinical summary records using CCM certified technology. However, there is no document type or section within existing EHRs that supports the functions needed to manage a care plan. There is a Plan of Care

section, but it does not support the elements that CMS calls for, let alone all of the elements that current care management processes require.

- The clinician must at least electronically capture care plan information—as noted above, current EHRs are not well designed to capture this information; therefore, it is likely that a parallel data capture system will be needed.
 - Care plan availability requirements call for practices to make information available on a 24/7 basis to all clinicians and staff within the practice whose time counts towards the time requirement for the practice to bill the CCM code. However, ACP remains concerned that practices using locally hosted EHR systems may be unable to support 24/7 remote access, or they may have to invest in such capabilities if they are available from their vendor.
 - Care plan sharing requirements call for practices to be able to share the care plan electronically (other than by fax) with other clinicians involved in the care of their patients. ACP remains concerned that, depending on location, there may be many options available for electronic exchange of clinical information, and a practice cannot be expected to invest in interfaces needed to connect to all communication options used by all external practitioners and providers with whom they must communicate. Additionally, since there are no requirements placed by this rule on external practitioners and providers, and since many of them will not be Eligible Providers in the Meaningful Use program, it is likely that many external clinicians and provider organizations will not have the capability to receive, view, edit, create, or send electronic care plans or care summaries in any form at all. Therefore, again, it is likely that practices will need to invest in supplemental HIT systems that can more effectively and efficiently share the care plan information. Fortunately, CMS is not requiring the use of a specific tool or service (such as an EHR) to exchange/transmit clinical summaries, as long as they are transmitted electronically (other than by fax).
3. The requirement for patients to pay the \$8 estimated coinsurance amount could potentially hinder beneficiary access and/or make it challenging to reach the 20 minutes required for billing, because beneficiaries may delay care until a face-to-face visit becomes necessary.

ACP understands that CCM services do not fall into any of the statutory preventive services benefit categories of the Affordable Care Act. The College also understands that CMS does not have the statutory authority that would allow them to waive the applicable coinsurance for CCM services. However, ACP remains concerned with the \$8 estimated coinsurance amount in the proposed rule. ACP will continue to explore different options regarding this coinsurance payment.

4. The participants in the Multi-Payer Advanced Primary Care Demonstration and the Comprehensive Primary Care Initiative could potentially be put at a disadvantage compared to their colleagues that are not participating in these models, but who will be able to bill for the CCM code.

ACP understands that duplicative payments would be inappropriate and respects that CMS acknowledges there may be appropriate opportunities for clinicians participating in the demonstration models to use the chronic care management code, even though this may be a limited number. However, ACP does not agree that the services provided in CMS Innovation Center projects are necessarily duplicative of those provided under the CCM code. Additionally, ACP is concerned that this exclusion may be discouraging to those participating in the Innovation Center models, particularly as these models do still involve a strong fee-for-service payment component.

Specific CCM Billing Requirements:

CCM 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 as outlined below are met:

CCM Scope of Service Element/Billing Requirement	Certified EHR or Other Electronic Technology
Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination, and ongoing clinical care.	Structured recording of demographics, problems, medications, medication allergies, and creation of structured clinical summary records using CCM certified technology.
Access to care management services 24/7 (providing the beneficiary with a means to make timely contact with health care providers in the practice to address his or her urgent chronic care needs regardless of the time of day or day of the week).	None
Continuity of care with a designated practitioner or member of the care team with whom the beneficiary is able to get successive routine appointments.	None
Care management for chronic conditions including systematic assessment of the beneficiary's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of beneficiary self-management of medications.	None
Creation of a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues. Share the care plan as appropriate with other practitioners and providers.	Must at least electronically capture care plan information; make this information available on a 24/7 basis to all practitioners within the practice whose time counts towards the time requirement for the practice to bill the CCM code; and share care plan information electronically (other than by fax) as appropriate with other practitioners and providers.
Provide the beneficiary with a written or electronic copy of the care plan and document its provision in the electronic medical record.	Document provision of the care plan as required to the beneficiary in the EHR using CCM certified technology.
Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing	<ul style="list-style-type: none"> • Format clinical summaries according to CCM certified technology. • Not required to use a specific tool or service to exchange/transmit clinical summaries, as long as they are transmitted electronically (other than by

CCM Scope of Service Element/Billing Requirement	Certified EHR or Other Electronic Technology
facilities or other health care facilities.	fax).
Coordination with home and community based clinical service providers.	Communication to and from home and community based providers regarding the patient's psychosocial needs and functional deficits must be documented in the patient's medical record using CCM certified technology.
Enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary's care through not only telephone access, but also through the use of secure messaging, internet, or other asynchronous non face-to-face consultation methods.	None
Beneficiary consent - Inform the beneficiary of the availability of CCM services and obtain his or her written agreement to have the services provided, including authorization for the electronic communication of his or her medical information with other treating providers. Document in the beneficiary's medical record that all of the CCM services were explained and offered, and note the beneficiary's decision to accept or decline these services.	Document the beneficiary's written consent and authorization in the EHR using CCM certified technology.
Beneficiary consent - Inform the beneficiary of the right to stop the CCM services at any time (effective at the end of the calendar month) and the effect of a revocation of the agreement on CCM services.	None
Beneficiary consent - Inform the beneficiary that only one practitioner can furnish and be paid for these services during a calendar month.	None

Resource-Based Practice Expense (PE) Relative Value Units (RVUs) Relevant to Site of Service

CMS is continuing to seek a better understanding regarding the growing trend toward hospital acquisition of physicians' offices and how the subsequent treatment of those locations as off-campus provider-based outpatient departments affects payments under PFS and beneficiary cost-sharing. MedPAC continues to question the appropriateness of increased Medicare payment and beneficiary cost-sharing when physicians' offices become hospital outpatient departments and to recommend that Medicare pay selected hospital outpatient services at PFS rates.

As more physician practices become hospital-based, it is difficult to know which PE costs are actually incurred by the physician, which are incurred by the hospital, and whether the bifurcated site-of service differential adequately accounts for the typical resource costs given these relationships. CMS has reviewed this issue as it relates to accurate valuation of visits within the postoperative period of 10- and 90-day global codes.

CMS believes that collecting data using an additional Healthcare Common Procedure Coding System (HCPCS) modifier and Place of Service (POS) code as finalized in this rule (and outlined in more detail below) will be an important tool in furthering the analysis of data captured on outpatient services furnished off of the hospital's main campus and off of any of the hospital's other campuses.

HCPCS Modifier

CMS is finalizing the proposal to create a HCPCS modifier for hospital services furnished in an off-campus hospital provider-based department (PBD) setting; however, they are adopting a voluntary reporting period for this new HCPCS modifier for the first calendar year (beginning January 1, 2015). That is, reporting the new HCPCS modifier for services furnished at an off-campus PBD will not be mandatory until January 1, 2016, in order to allow clinicians and provider organizations time to make the needed systems changes, test these changes, and train staff on the use of the new modifier before reporting is required. CMS proposed that this new HCPCS modifier would be reported on both the CMS-1500 claim form for physicians' services and the UB-04 for hospital outpatient claims. ACP is supportive of this early reporting of the modifier and believes a full year of preparation should provide hospitals with sufficient time to modify their systems for accurate reporting.

New POS Codes

With respect to the POS code for professional claims, CMS will request two new POS codes to replace POS code 22 (Hospital Outpatient). Once the revised POS codes are ready and integrated into CMS claims systems, EPs would be required to use them, as applicable. More information on the availability of the new POS codes will be forthcoming in sub-regulatory guidance, but CMS does not expect the new codes to be available prior to July 1, 2015. There will be no voluntary reporting period of the POS codes for applicable professional claims because each professional claim requires a POS code in order to be accepted by Medicare. However, CMS does not view this to be problematic because they intend to give prior notice on the POS coding changes and, as many public commenters noted, because EPs are already accustomed to using a POS on every claim they submit.

Relevant ACP Policy

In addressing the issue of provider-based billing, also commonly referred to as hospital outpatient billing, ACP recognizes the importance of balancing the needs of the community and the unintended consequences of abolishing provider-based billing. In many rural areas, hospitals and patients rely on the care provided in these settings. In addition, abolishing provider-based billing could have an effect on salaries of physicians employed by such entities, an effect on medical education programs at such entities, and an effect on availability of services provided to uninsured patients at such entities. The College believes that care should be provided in the most efficient setting possible, while maintaining quality of care, and supports policies consistent with the statements below.

- 1. The College does not support provider based billing for care delivered in an outpatient, hospital-system owned practice when that care is not dependent on the hospital facility and its associated technologies. Rather, in line with the College's high value care initiative, the College supports delivery of care in the most efficient setting, while maintaining quality of care**
- 2. Hospitals and hospital-owned outpatient practices should be transparent about their billing policies with patients prior to providing care, particularly if the patient and/or their health plan will be responsible for both physician service and hospital facility fees.**

3. **Provider based billing should not be used as a mechanism for hospitals to recoup/stabilize funding or as a means of ensuring access to care. Ensuring adequate hospital funding and patients’ access to care can better be addressed and supported through other means, such as increased/improved health insurance coverage, strengthened workforce policies, and delivery system reforms.**

Additional detail on ACPs policy regarding provider-based billing can be found at: http://www.acponline.org/acp_policy/policies/provider_based_billing_2013.pdf.

Potentially Misvalued Services under the Physician Fee Schedule

Consistent with changes required by the Affordable Care Act, CMS, ACP, AMA, and other medical societies have been engaged in a vigorous effort over the past several years to identify and review potentially misvalued codes, and make adjustments where appropriate.

CMS stated that they believed that a review of the codes in Table 11 (below) is warranted to assess changes in physician work and to update direct PE inputs since these codes have not been reviewed since CY 2009 or earlier. Furthermore, since these codes have significant impact on PFS payment at the specialty level, a review of the relativity of the codes is essential to ensure that the work and PE RVUs are appropriately relative within the specialty and across specialties. For these reasons, CMS finalized the codes listed in Table 11 as potentially misvalued. The College will continue to weigh in on the revaluation of the CMS identified misvalued codes which are heavily utilized by Internal Medicine through our role in the CPT/RUC process.¹

TABLE 11: Potentially Misvalued Codes Identified Through the High Expenditure by Specialty Screen

HCPCS Short Descriptor
75978 Repair venous blockage (6.99% by IM)
76536 Us exam of head and neck (9.71% by IM)
76700 Us exam abdom complete(14.28% by IM)
76770 Us exam abdo back wall comp (8.21% by IM)
76775 Us exam abdo back wall lim (15.82% by IM)
78452 Ht muscle image spect mult (5.28% by IM)
91110 Gi tract capsule endoscopy (5.77% by IM)
93306 Tte w/doppler complete (10.52% by IM)
93351 Stress tte complete (7.25% by IM)
93978 Vascular study (9.79% by IM)

¹ NOTE: Under the Protecting Access to Medicare (PAMA) Act (i.e, the SGR patch), the temporary measure that keeps current rates in place through March 2015, the Centers for Medicare and Medicaid Services had been directed to continue examining potentially "misvalued codes" next year and reach a target for identifying these misvalued services of 0.5 percent starting in 2017. If the target is met, that amount is to be redistributed in a budget-neutral manner within the physician fee schedule. If the target is not met, fee schedule payments for the year are reduced by the difference between the target and the amount of misvalued services identified in a given. However, the Achieving a Better Life Experience (ABLE) Act, which was passed in December 2014, doubles the amount of that target, and therefore the amount at risk to be cut to 1 percent cut on all Medicare reimbursements. The ABLE Act also moves up the start date for this target to be met to 2016. CMS noted in this final rule that they will choose to focus their resources on revaluing surgical global codes (discussed later in this document) rather than those noted to be potentially misvalued codes, it is a near certainty that this 1 percent cut will go into effect starting in 2016.

HCPCS Short Descriptor
94010 Breathing capacity test (23.25% by IM)
95004 Percut allergy skin tests (8.92% by IM)
96372 Ther/proph/diag inj sc/im (25.90% by IM)
96375 Tx/pro/dx inj new drug addon
96401 Chemo anti-neopl sq/im (6.46% by IM)

*Percentages based on 2012 Medicare Data

Radiation Therapy and Gastroenterology

Consistent with the final rule policy and in response to public comments, CMS is not adopting code changes for gastroenterology and radiation therapy services until they can go through notice and comment rulemaking to propose values for 2016. As a result of this decision, CMS will not recognize some new CPT codes, and will create G-codes in place of CPT codes to continue current payment rates for CY 2015.

Mammography

Additionally, after consideration of public comments, CMS finalized the following:

- CMS will review CPT codes 77055, 77056, and 77057 with the complete code family as potentially misvalued, since the descriptors for these codes specifically refers to film;
- CMS will continue to recognize G0202, G0204 and G0206 but will modify the descriptors so that they are specific to 2-D digital mammography, and instead of using the digital values, will continue to use the CY 2014 work and PE RVUs to value the mammography CPT codes. These codes (G0202, G0204 and G0206) are to be reported with either G0279 or CPT code 77063 when mammography is furnished using 3-D mammography.

CMS also noted that they expect that the CPT Editorial Panel will consider the descriptor for screening mammography, CPT code 77057, in light of the prevailing use of digital mammography.

Abdominal Aortic Aneurysm Ultrasound Screening

CMS is finalizing the code G0389 (Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening) as potentially misvalued in large part because they are unsure of the correct valuation. CMS believe it is most appropriate to retain the 2013 inputs until they receive new recommendations rather than making another change or retaining these inputs indefinitely.

Obesity Behavioral Group Counseling

CMS will crosswalk the work RVU of 0.25 and the work time of 10 minutes to a single new G-code for group obesity counseling, G0473 (Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes). CMS agrees that it is reasonable to create a single code for group obesity counseling and crosswalk the work RVU and work time from the medical nutrition therapy (MNT) group code (97804 Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes). The individual code for intensive obesity behavioral therapy and the individual MNT code are valued the same, so in the absence of evidence that group composition is different, CMS believes it makes sense to use the same values.

Improving the Valuation and Coding of the Surgical Global Package

CMS will retain global bundles for surgical services, but will refine bundles by transforming over several years all 10- and 90-day global codes to 0-day global codes. Medically reasonable and necessary visits would be billed separately during the pre- and post-operative periods outside of the day of the surgical procedure. CMS will make this transition for current 10-day global codes in CY 2017 and for the current 90-day global codes in CY 2018, pending the availability of data on which to base updated values for the global codes.

ACP believes it would be advantageous for RUC and CMS to work collaboratively to explore the available appropriate group practice data and CMS data to validate the actual number of post-operative visits. CMS, along with the RUC, could also review the Medicare Part A claims data to determine the length of stay of surgical services performed in the hospital facility setting. Matching the average length of stay with the post-operative visits in the physician time file would provide the opportunity to identify anomalies within the data set that could be further reviewed. The RUC, working along with CMS, could review post-operative visit length of stay data for outliers.

ACP recognizes that the codes with very low and negative intra-service work per unit of time (IWPUTs) would have to be surveyed as directed by CMS instruction to the RUC that this be performed. [Rasch](http://www.rasch.org/florin.htm) pairings (For additional information on Rasch pairing: <http://www.rasch.org/florin.htm>) would be an acceptable methodology for surveying large numbers of codes in a family, perhaps supplemented by a standard survey of several "anchor" codes, to establish the work RVUs. The College will continue to engage with CMS in an effort to reach an agreement that is equitable for all stakeholders.

Revisions to Geographic Practice Cost Indices (GPCIs)

As required by the Medicare law, CMS adjusts payments under the PFS to reflect local differences in the cost of operating a medical practice. For CY 2015, CMS is using territory-level wage data to calculate the work GPCI and employee wage component of the PE GPCI for the Virgin Islands. The CY 2015 GPCIs also reflect the application of the statutorily mandated 1.5 work GPCI floor in Alaska, and 1.0 work GPCI floor for all other physician fee schedule areas, and the 1.0 PE GPCI floor for frontier states (Montana, Nevada, North Dakota, South Dakota, and Wyoming). However, given that the statutory 1.0 work GPCI floor is scheduled to expire under current law on March 31, 2015, the GPCIs outlined in this final rule reflect the elimination of the 1.0 work GPCI floor from April 1, 2015 through December 31, 2015.

Valuing New, Revised, and Potentially Misvalued Codes

CMS finalized that beginning with the PFS proposed rule for CY 2016, CMS will include the proposed values for all new, revised and potentially misvalued codes for which CMS has complete RUC recommendations by **February 10th** of the preceding year (this is a change from the proposed deadline of January 10th—a change that the College had called for in our comments). For RUC recommendations received after February 10th, CMS will delay revaluing the code for one year and include proposed values in the following year's rule. However, there will be flexibility in the implementation of the process for CY 2016 in that for any new, revised, and misvalued code recommendations received after February 10, 2015, CMS plans to establish interim final values for them for CY 2016, consistent with the current process. This phased implementation is intended to ensure that those who have requested new codes and modifications in existing codes with the expectation that they would be valued under the PFS for CY 2016 will not be negatively affected by the timing of this change.

Then, beginning in CY 2017, for a revised or misvalued CPT code value recommendation received after February 10th, CMS will create a G code for the next year to describe the predecessor code—since it will no longer be listed in the CPT manual—and pay at the old rate until it is revalued.

Also beginning in CY 2017, for wholly new CPT code value recommendations received after February 10th for which CMS decides it is in the best interest to establish values for the following year on an interim final basis, CMS would “contractor price” (individual Medicare Administrative Contractors set their own reimbursement value) the code for the initial year.

ACP had called on CMS to delay implementation of this new approach until CY 2017 and therefore is pleased that the Agency chose a phased approach rather than full implementation in CY 2016, as was originally proposed.

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

CMS finalized a change to current regulations which state that services furnished “incident to” an RHC or FQHC visit must be provided by an employee of the RHC or FQHC. ACP was supportive of this change to the “incident to” requirement for RHCs and FQHCs that has been a burden on physicians and staff that do not fit this description. Expanding the capacity of nurses, medical assistants, and other auxiliary personnel by allowing them to furnish “incident to” services under contract in RHCs and FQHCs will ease the staffing difficulties that physicians currently face in these settings.

Medicare Telehealth Services

CMS finalized four services that will be eligible for telehealth payment. These services are:

- Medicare’s annual wellness visit (coded with HCPCS G0438 and G0439)
- Prolonged evaluation and management services (reported with CPT codes 99354 and 99355)
- Family psychotherapy (CPT codes 90846 and 90847)
- Psychoanalysis (CPT code 90845)

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

CMS finalized a proposal to use its 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. Both public and private sector participants are subject to this. According to the rule, 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.

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

The final rule implements a significant change to the Open Payments program, which requires the public reporting of specified transfers of value or ownership interests involving applicable healthcare industries (e.g., pharmaceutical and durable medical equipment companies) and covered physicians and teaching

hospitals. The change addresses industry-subsidized continuing medical education (CME) events and affects both the CME event speakers and attendees.

Under the current regulations, neither speaker payment or subsidized tuition fees linked to applicable industry are reportable if the event meets 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).

Under the new final rule, industry-linked speaker payment or subsidized tuition fees for CME events are not reportable only if one of the following criteria is met:

- Where applicable industry is "unaware" of, that is, "does not know," the identity of the covered recipient during the reporting year or by the end of the second quarter of the following reporting year; or
- Where applicable industry provides funding to support a continuing education event but does not require, instruct, direct, or otherwise cause the CME provider to provide the payment or other transfer of value in whole or in part to a covered recipient -- a "no strings attached" funding.

CMS states that this change was made for several reasons including to remove the appearance of CMS endorsing specific CME accreditation/certification entities, to reduce regulatory redundancy, and to increase consistency and clarity in reporting. In order to provide time for applicable industry to develop processes to meet this change in reporting requirements, it will not be implemented until January 1, 2016.

Medicare Shared Savings Program

The final rule outlines several changes to the Medicare Shared Savings Program, including:

- Modifying the quality scoring system to recognize and reward accountable care organizations (ACOs) that make year-to-year improvements in quality performance scores on individual measures, in addition to the current strategy of rewarding quality points based upon meeting absolute performance thresholds. The College has been a supporter of this change, and further appreciates CMS increasing the number of potential quality points (from 2-4 points) obtainable from year-to-year improvement.
- Modifying the rate in which benchmarks are reset from 1 to 2 years. This will promote more stable quality improvement targets.
- Modifying the quality measures to reflect up-to-date clinical guidelines and practices, reduce duplicative measures, increase the use of claims-based outcome measures, and reduce overall reporting burden. While keeping the number of required quality reporting measures the same (through elimination of several measures) at 33, CMS has finalized the following new measures:
 - Avoidable admissions for patients with multiple chronic conditions, heart failure and diabetes;
 - Depression remission;
 - All cause readmissions to a skilled nursing facility;
 - Documentation of current medications; and
 - Stewardship of patient resources

- Each new measure will be “pay-for-reporting” for its first two reporting periods in use, rather than pay for performance for the ACO. This is an appropriate strategy in that it helps to ensure that ACOs have adequate time to phase in their own care processes and infrastructure before they are held accountable for performance and that CMS has adequate data to set benchmarks for new measures before they transition to pay for performance

Overall, the finalized changes support CMS’s attempt to align requirements for ACOs with the Meaningful Use, PQRS and the Value-Modifier programs.

Physician Compare Website

In the final rule, CMS continues its phased in approach to developing the Physician Compare website to include information on physicians and eligible professionals (EPs) enrolled in the Medicare program. CMS finalized that it will continue to report satisfactory individual and GPRO PQRS reporters, satisfactory reporters on the clinically relevant measures that are part of the Million Hearts initiative, and those that earned the 2014 PQRS Maintenance of Certification Incentive on the website.

For individual EPs, CMS finalized that it will publicly report all 2015 measures for individual EPs collected through a registry, EHR, or claims, except for those measures that are new to PQRS and therefore in their first year.

For groups, CMS finalized the reporting of all 2015 PQRS measures via all reporting options for group practices of 2 or more EPs participating in PQRS GPRO, and all 2015 measures reported by ACOs (with the ACO measures being reported on Physician Compare in the same way as for group practices). CMS further stated that all group practices and ACOs will be given a 30-day preview period of their measures prior to publication on the website. Group practices and EPs will be informed via email when this preview period will take place and will be provided with a detailed timeline and instructions for this preview. Additionally, CMS finalized that it would make available for public reporting the 12 summary survey measures from the CAHPS for PQRS survey for group practices and ACOs, as appropriate; however, they will not be adopting any benchmarks for CAHPS for PQRS on Physician Compare.

For QCDR participants, CMS finalized that they will publicly report QCDR 2015 data on the Physician Compare website in 2016, excluding those measures that are in their first year of use. These data will only be reported at the individual EP level, and not at the group practice level.

CMS finalized that it will include all measures in a downloadable file, while still limiting the measures available on the website profile pages to those that fully meet the public reporting requirements of validity, reliability, accuracy, comparability, and ease of understanding by consumers. CMS noted its plan to continue to conduct consumer testing for both usability of the Physician Compare website and understanding of the measures that are publicly reported.

CMS did not finalize its proposal to create composites using 2015 data and then publishing those composite scores in 2016; however, they noted that they will consider proposing these composites again in future rulemaking. CMS also did not finalize its proposal to publicly report benchmarks for 2015 PQRS GPRO on Physician Compare in 2016. The agency noted the need to more thoroughly discuss potential benchmarking methodologies with key stakeholders, and to evaluate other programs’ methodologies (such as the Value Modifier) before moving forward. Additionally, CMS did not finalize

its proposal to include specialty measures on Physician Compare, but stated that they may consider addressing them in future rulemaking.

Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System (PQRS)

In the final rule, CMS continued the reporting mechanisms that were in place in 2014 for 2015 reporting. Therefore, individual eligible professionals (EPs) can report via: claims, qualified registry (for individual measures), measure groups via registry, certified EHR (or EHR submission vendor), or qualified clinical data registry (QCDR). However, CMS did note that their intention is to eliminate the claims reporting mechanism for individual EPs in future rulemaking, so they are strongly encouraging all EPs to use alternative reporting mechanisms as soon as possible. Groups can report using the GPRO web interface, qualified registry, or via certified EHR (or EHR submission vendor). Groups can also use a certified survey vendor for the CAHPS for PQRS reporting.

In 2015, it is important to note that all EPs that do not meet the criteria for satisfactory reporting for the 2017 PQRS payment adjustment will be subject to the negative 2 percent adjustment, with no exceptions.

For all EPs and groups that are reporting individual measures via all mechanisms in 2015, CMS finalized that they are required to report on at least 9 measures, covering 3 National Quality Strategy (NQS) domains. This is generally aligned with the approach CMS took in 2014; however, ACP recommends that physicians check with CMS directly for specific reporting requirements based on their chosen reporting mechanism. Each of these measures must be reported for at least 50 percent of the EP's Medicare Part B patients for which the measure applies—or for 50 percent of all of their patients (including non-Medicare), if using the QCDR mechanism. Also, like in 2014, if an EP does not have at least 9 measures applicable to his/her practice, then the EP may report on 1-8 measures and will be subject to the Measures Application Validity (MAV) process (more information on the 2015 MAV process will be posted on the CMS website). CMS also finalized a new requirement for individual EP claims and registry-based reporting. This new requirement is that if an EP sees at least one Medicare patient in a face-to-face encounter (telemedicine visits are not included), then they are required to report on at least one cross-cutting measure from a designated set of these measures.

This is the second year that CMS is allowing satisfactory participation in a QCDR to qualify for successful PQRS participation. QCDRs must collect quality measures data on patients for Medicare, as well as private payers. They must be able to provide at least 4 feedback reports to each of its participating EPs during the year for which it is qualified and must possess benchmarking capacity that measures the quality of care an EP provides with other EPs providing the same or similar functions. For 2015, CMS has made several modifications to the requirements for QCDRs. First, CMS is now requiring that a QCDR must possess at least 2 outcomes measures—or if it does not have 2 outcomes measures, then it must have 1 outcome measure and 1 of the following other types of measures: resource use, patient experience of care, efficiency/appropriate use, or patient safety. Second, CMS finalized the option that QCDRs may submit quality measures data for a maximum of 30 non-PQRS measures (in addition to as many PQRS measures as they wish)—this is an increase in the number of optional non-PQRS measures allowed for 2014. Third, CMS finalized that the entities must make public the quality measures data that its EPs report via a QCDR; however, CMS instituted an exception to this requirement for all PQRS and non-PQRS measures in their first year of reporting by a QCDR. These public reporting mechanisms include Physician Compare, as well as board or specialty websites, listserv dashboards, or other

announcements; those publicly reporting outside of Physician Compare must do so by 2016. Entities using QCDRs can also determine whether to report performance results at the individual EP-level or aggregate the results. Finally, CMS finalized an extension of the deadline for QCDRs to submit quality measures data, to March 31, 2016, for reporting periods ending in 2015.

For reporting of measures groups via registry for 2015, CMS largely finalized the same requirements from 2014—that EPs must report at least 1 measures group AND report each measures group for at least 20 patients, the majority (11 patients) of which are required to be Medicare Part B FFS patients. However, CMS did modify the definition of a PQR measures group to be a subset of six or more PQR measures that have a particular clinical condition or focus in common. Additionally, two new measures groups were added for 2015: the Sinusitis and Acute Otitis Externa (AOE) measures groups.

CMS also made some changes to the GPRO web interface reporting requirements for 2015. First, the deadline by which a group practice must register to participate in the GPRO has been moved up to June 30 of the year in which the reporting period occurs—for 2015 and future years (this deadline was September 30 in 2014). This new deadline refers to all group practices wishing to participate in the GPRO—via GPRO web interface, registry, EHR, and/or CMS-certified survey vendor. Second, for groups of 25-99 EPs using the GPRO web interface, the group must report on all measures included in the web interface AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries. Third, for groups of 100 or more EPs that register to participate in the PQR GPRO, reporting of CAHPS for PQR (defined as the Agency for Healthcare Research and Quality's Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CAHPS), with some additional supplemental items and questions added for the PQR program) is now required. Reporting of CAHPS for PQR is optional for groups of 2-99 EPs. Additionally, CMS will no longer be able to bear the cost of administering CAHPS for PQR.

In terms of the specific measures to be used for PQR reporting in 2015, CMS made several NQS domain category changes to the existing measures, added 20 new individual measures and two measures groups to fill existing measure gaps, and removed 50 measures from reporting for the PQR. These changes bring the total number of PQR individual measures to 255.

Value-Based Payment Modifier and Physician Feedback Program

As is required by statute, in the 2015 final rule, CMS stated that it will begin to apply the Value Modifier in calendar year (CY) 2017 to all physicians—including those in solo practice and in groups of 2 or more EPs—as well as to all non-physician EPs in CY 2018. CMS also finalized that, beginning with the CY 2017 payment adjustment period, the Value Modifier will apply to all physicians and non-physician EPs that participate in ACOs under the Medicare Shared Savings Program, the Pioneer ACO Model, and the Comprehensive Primary Care Initiative, or other similar Innovation Center models or CMS initiatives. It is important to note that the reporting year for the application of the Value Modifier in CY 2017 is CY 2015—therefore, all physicians will be included in the Value-Based Payment Modifier and Physician Feedback program starting in 2015 (with their Medicare payments being impacted by the program in 2017). All non-physician EPs will be included starting in 2016, with their Medicare payments being impacted in 2018.

CMS continues to use a two-category approach for the CY 2017 Value Modifier based on successful participation in PQR. Category 1 includes groups that meet the criteria for satisfactory reporting of data on PQR during 2015 via GPRO and groups that have at least 50% of their EPs meet the criteria for satisfactory reporting of data on PQR as individual reporters, or in lieu of satisfactory reporting,

participate in a PQRs qualified clinical data registry (QCDR). Category 1 also now includes solo clinicians that meet the criteria for satisfactory reporting or, in lieu of satisfactory reporting, participate in a PQRs QCDR. Category 2 includes all other groups or solo clinicians.

CMS finalized the amount of payment at risk in CY 2017 based on successful 2015 PQRs participation. Groups of 10 or more EPs that do not meet the reporting requirements for PQRs in 2015 (i.e., that fall into Category 2) will be subject to a downward adjustment of -4.0 percent in CY 2017. Solo physicians and non-physician EPs and groups of 2-9 EPs that do not meet the reporting requirements for PQRs in 2015 will be subject to a downward adjustment of -2.0 percent in CY 2017. This is a change from CMS' original proposal to have all EPs, including solo and small groups, subject to a -4.0 percent penalty if they do not successfully participate in PQRs. It is important to note that the CY 2017 Value Modifier downward payment adjustments for those that are not successfully participating in PQRs are in addition to the PQRs program downward adjustment of -2.0 percent described earlier.

For all physicians and groups that fall into Category 1 as described above, CMS finalized that they are subject to quality-tiering to determine their CY 2017 Value Modifier payment adjustment (based on their CY 2015 data). As it is their first year in the program, solo EPs and groups with 2-9 EPs will be held harmless from any downward adjustments and are only subject to either neutral or upwards payment adjustments based on where they fall within the quality tiers. However, groups of 10 or more EPs will be subject to upward, neutral, or downward payment adjustments determined under the quality-tiering methodology. Below is a summary of the payment adjustments under the quality-tiering methodology:

CY 2017 – Finalized Value Modifier Quality-Tiering Methodology			
Quality/Cost	Low Cost	Average Cost	High Cost
High Quality	+4.0x*	+2.0x*	+0.0%
Average Quality	+2.0x*	+0.0%	-2.0%
Low Quality	+0.0%	-2.0%	-4.0%

* Risk-adjusted for high-risk beneficiaries

CMS cannot determine the specific upward payment amount percentages, since the total sum of downward adjustments is unknown at this time; however, the individual EPs or groups that are determined to provide high quality and low cost care will receive the highest upward adjustment.

For CY 2017, the Value Modifier quality composite score will be based on PQRs quality measures that are reported via all available PQRs reporting mechanisms, plus three additional claims-based measures that CMS will calculate. Additionally, groups of 2 or more EPs can elect to have the patient experience of care measures collected through the CAHPS for PQRs survey in CY 2015 included in their quality of care composite for the CY 2017 payment adjustment. The CY 2017 cost composite will be calculated using the same cost measures that were finalized in the 2014 final rule—five total per capita cost measures and the Medicare Spending per Beneficiary (MSPB) measure.

Informal Inquire Process and Physician Feedback Program

CMS finalized that it will expand the informal inquiry process starting with the CY 2015 payment adjustment period to allow solo and group EPs a brief window to request a correction of a perceived error prior to application of the Value Modifier payment adjustment. The Agency disseminates this information through the Quality and Resource Use Reports (QRURs) to all solo and group EPs. These QRURs contain performance information on the quality and cost measures used to calculate the quality

and cost composites of the Value Modifier for CY 2015 payment adjustments (however, the 2015 payment adjustments are only applicable for physicians in groups of 100 or more EPs).

For the CY 2015 payment adjustment period (based off of CY 2013 data), CMS made the QRURs available on September 30, 2014. The final rule extends the deadline to request a correction on these QRURs from January 31 to February 28, 2015. Beginning with the CY 2016 payment adjustment period, CMS will allow 60 days after the release of the QRURs for group or solo EPs to request a correction.