

Summary of the 2015 final Medicare physician fee schedule

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Executive Summary

On October 31, the Centers for Medicare & Medicaid Services (CMS) issued a [final rule](#) that updates payment policies and rates for services furnished under the Medicare physician fee schedule beginning January 1, 2015. In an AAFP [statement](#) released after the final rule became available, the AAFP expressed “disappointed that, once again, current law requires CMS to slash Medicare physician payment by 21.2 percent on April 1, 2015. Without Congressional action to permanently repeal the sustainable growth rate formula that requires this devastating cut, Medicare patients will continue to struggle with insecure access to health care.” The current Medicare conversion factor through March 31, 2015 is \$35.8013. Unless Congress intervenes, starting on April 1, 2015, the conversion factor will be \$28.2239.

Medicare predominately pays physicians and other practitioners for care management services as part of face-to-face visits. However, citing a commitment to support primary care, CMS will begin payment in 2015 for managing the care of Medicare patients with two or more chronic conditions outside of a face-to-face visit. The Medicare allowance for this Chronic Care Management (CCM) service will be \$42.60 and the service can be billed no more frequently than once per month per qualified patient.

As part of the final rule’s release, CMS issued fact sheets discussing [overall payment policy changes](#), outlining [changes to the quality reporting programs](#), and summarizing [policies on the value modifier](#). The AAFP sent CMS extensive regulatory comments on the proposed 2015 Medicare physician fee schedule in an August 26, 2014 [letter](#) on payment issues and in an August 1, 2014 [letter](#) on the Continuing Medical Education changes to the Open Payment program.

Chronic Care Management (CCM) services

Background

In comments during the 2014 rulemaking cycle, the AAFP generally supported the CMS proposal to pay CCM services in 2015 and agreed that the existing evaluation and management (E/M) codes do

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not adequately reflect resources required to properly provide CCM services to beneficiaries with multiple chronic conditions.

In the 2014 final rule, CMS established policy to make separate payment for non-face-to-face CCM services for Medicare beneficiaries who have multiple, significant chronic conditions (two or more). CCM services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management.

Within the 2014 rulemaking cycle, CMS also finalized that CCM services include:

- Access to care management services 24-hours-a-day, 7-days-a-week, which means providing beneficiaries with a way to make timely contact with health care providers in the practice to address the patient's urgent chronic care needs at all times.
- Continuity of care with a designated practitioner or member of the care team with whom the patient is able to have successive routine appointments.
- Care management for chronic conditions including systematic assessment of the patient'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 patient self-management of medications.
- Documentation of a patient-centered care plan to assure that care is provided in a way that is congruent with the patient's choices and values. A plan of care is based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports. It is a comprehensive plan of care for all health issues.
- Management of care transitions among health care providers and settings, including referrals to other clinicians, follow-up after a beneficiary visit to an emergency department, and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities.

2015 proposed changes

Before discussing the CCM code, CMS reiterates a commitment to supporting primary care and lists a series of initiatives designed to improve payment for care management services, and encourages long-term investment in them. The CMS list includes the Medicare Shared Savings Program, the Pioneer Accountable Care Organization (ACO) model, the Advance Payment ACO model, the Primary Care Incentive Payment (PCIP) program, the Multi-payer Advanced Primary Care Practice (MAPCP) demonstration, the Federally Qualified Health Center (FQHC) Advanced Primary Care Practice demonstration, and the Comprehensive Primary Care (CPC) initiative.

In the 2015 rule, CMS proposed a payment rate of \$41.92 for the CCM code, which would be a G-code of CMS's creation. CMS also proposed that it could be billed no more frequently than once per month per qualified patient.

CMS proposed to remove the requirement that the clinical staff person must be a direct employee of the practitioner or the practitioner's practice in order to count the clinical staff person's time in providing aspects of CCM services toward the CCM time requirement. CMS also proposed 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 addition to the criteria established in 2014, CMS proposed a new scope-of-service requirement for electronic care planning capabilities and electronic health records. Specifically, CMS proposed that CCM services must be furnished with the use of an electronic health record or other health IT or health information exchange platform that includes an electronic care plan that is accessible to all providers within the practice, including 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. In the proposed

rule, practitioners furnishing CCM services beginning in 2015 would be required to utilize an electronic health record certified to at least 2014 edition certification criteria.

AAFP recommendations

The AAFP thanked CMS for identifying that CCM services for beneficiaries with multiple chronic conditions are not adequately reflected in the existing evaluation and management codes, however, the AAFP expressed several concerns with the proposal and urged CMS to consider phasing in the required use of an electronic health record.

Final policy

CMS finalized a payment rate of \$42.60 for a one per month per patient CCM code. Rather than use the proposed G-code, CMS will utilize CPT code 99490.

CMS finalized revisions to the 2014 PFS final rule regarding “incident to” services. As finalized, TCM and CCM services provided by clinical staff incident to the service of a practitioner can be furnished under general supervision of a physician or other practitioner and the clinical staff need not be a direct employee of the practitioner or practitioner’s practice.

Rather than require 2014 certified EHR technology, CMS relaxed that proposal and will require the version of the certified EHR in use on December 31 of the prior year for the EHR Incentives Programs to bill for CCM services.

Medicare Telehealth Services

Background

CMS defines Medicare telehealth services to include consultations, office visits, office psychiatry services, and any additional service specified by CMS when delivered via an interactive telecommunications system. CMS defines an interactive telecommunications system as “multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way real time interactive communication between the patient and the practitioner at the distant site.” CMS notes that telephones, fax machines, and email systems do not meet this definition.

The law provides for coverage of and payment for consultation services delivered via a telecommunications system to Medicare beneficiaries residing in rural health professional shortage areas (HPSAs). Provided that the health care professional is licensed under state law to deliver the service being furnished via a telecommunications system, eligible providers at the distant site include physicians, physician assistants, nurse practitioners, clinical nurse specialists, nurse-midwives, clinical psychologists, clinical social workers, registered dietitian, or nutrition professionals.

In 2002, CMS established an annual process for the public to suggest the addition or deletion of services from the list of Medicare telehealth services. These requests must be submitted no later than December 31 of each calendar year to be considered for the next rulemaking cycle.

2015 proposed changes

CMS proposed to add the following services to the list of services that can be furnished to Medicare beneficiaries under the telehealth benefit:

- Psychotherapy services (CPT codes 90845, 90846 and 90847).
- Prolonged E/M services in the office/outpatient setting (CPT codes 99354 and 99355).
- Annual wellness visit (HCPCS codes G0438 and G0439).

AAFP recommendations

The AAFP fully supported the proposal to add codes to the list of covered Medicare telehealth services.

Final policy

CMS finalized the policy as proposed; thus beginning on January 1, 2015, Medicare will pay for the following services delivered via telehealth:

- Annual wellness visit (HCPCS code G0438)
- Psychoanalysis (CPT code 90845)
- Psychoanalysis (Family psychotherapy without the patient present, CPT 90847 and family psychotherapy with patient, CPT 908046)
- Prolonged E/M services requiring direct patient contact (CPT code 99354).

Misvalued Codes

Background

In recent years, CMS and the Relative Value Scale Update Committee (RUC) have taken steps to identify and address potentially misvalued codes. In lieu of the traditional 5-year review of RVUs, CMS and the RUC now identify and review potentially misvalued codes annually. *The Affordable Care Act* requires CMS to periodically identify, review, and adjust values for potentially misvalued codes with an emphasis on codes that:

- Have grown the most,
- Have experienced substantial changes in practice expenses,
- Are recently established for new technologies or services,
- Are multiple ones frequently billed together in conjunction with furnishing a single service,
- Have low relative values, particularly those that are often billed multiple times for a single treatment,
- Are so-called 'Harvard valued codes,' which have not been reviewed since the implementation of the Resource-Based Relative Value Scale (RBRVS), or
- Are determined inappropriate by CMS.

The *Protecting Access to Medicare Act* further expanded the categories of codes that CMS is directed to examine by adding nine additional categories of codes that:

- Account for the majority of spending under the PFS;
- Experienced a substantial change in the hospital length of stay or procedure time;
- May be a change in the typical site of service since the code was last valued;
- Have a significant difference in payment for the same service between different sites of service;
- May have anomalies in relative values within a family of codes;
- May have efficiencies when a service is furnished at the same time as other services;
- Have high intra-service work per unit of time;
- Have high PE RVUs; and
- Have high cost supplies.

2015 proposed changes

CMS proposed to add nearly 80 codes to the list of potentially misvalued codes. CMS identified most of these by reviewing high-expenditure services by a specialty that have not been recently reviewed. However, CMS identified other services in a variety of ways, including a public nomination process.

Notably, CMS proposed to refine the way in which the agency accounts for infrastructure costs associated with radiation therapy equipment, resulting in a payment reduction for radiation therapy services. CMS also proposed to update the practice expense inputs for x-ray services to reflect that x-rays are currently done digitally rather than with analog film.

CMS also proposed to enhance the transparency in setting Medicare Part B rates to ensure all revisions to payment inputs are subjected to public comment prior to being used for payment.

AAFP recommendations

The AAFP also supported the agency's efforts to identify and review potentially misvalued codes. The AAFP urged CMS to create separate primary care E/M codes for office or other outpatient services for new and established patients with correspondingly higher relative values.

Final policy

CMS finalized that screening codes identified as "high expenditure" are valid and will be used in the future. However, given the effort necessary to implement its global surgery payment change (see below), CMS decided not to finalize its proposal to simultaneously review the 67 codes previously identified through the high expenditure screen. CMS did make major decisions about misvalued codes in 2015 for Hip and Knee Replacements, Radiation Therapy and Gastroenterology, Radiation Therapy, Epidural Pain Injections, and Film to Digital Substitution.

CMS also revised the process used for establishing fee schedule payment rates by allowing for public comments to be made on changes before they become effective.

Global Surgery

Background

In the 2013 rulemaking cycle, CMS discussed a concern that current efforts to validate RVUs in the fee schedule do not go far enough to assess whether the valuation of global surgical packages reflects the number and level of post-operative services that are typically furnished. To support its statutory obligation to identify and review potentially misvalued services and to respond to the Inspector General who suggested that global surgical package payments are misvalued, CMS proposes to gather more information on the E/M services that are typically furnished with surgical procedures.

2015 proposed changes

CMS proposed to transform all 10- and 90-day global codes to 0-day global codes beginning in 2017 with a transitional period. Medically reasonable and necessary visits would be billed separately during the pre- and post-operative periods outside of the day of the surgical procedure.

AAFP recommendations

The AAFP supported CMS' proposals regarding how to improve the valuation and coding of the global surgical package. As noted in the AAFP's response to the proposed 2013 Medicare physician fee schedule, the AAFP supports efforts to improve the valuation of the global surgical package. To that end, the AAFP sent CMS a [letter](#) on February 20, 2013, that offered detailed suggestions on ways the agency can improve the valuation of the global surgical package. The AAFP supported CMS's intent to both investigate this area of potentially misvalued codes and to do so outside the RUC process.

Final policy

CMS finalized policy that begins with 10-day global services in 2017 and follows with the 90-day global services in 2018. As part of this, the agency will actively assess whether there is a better construction of a bundled payment for surgical services that provides incentives for care coordination and care redesign across an episode of care.

Off-Campus Provider-Based Departments

Background

Within the larger discussion on PE RVUs, CMS is seeking a better understanding of the growing trend toward hospital acquisition of physician offices and subsequent treatment of those locations as off-

campus, provider-based, outpatient departments. CMS remains concerned about the validity of the resource data as more physician practices become provider-based:

Our current PE methodology primarily distinguishes between the resources involved in furnishing services in two sites of service: the non-facility setting and the facility setting. In principle, when services are furnished in the non-facility setting, the costs associated with furnishing services include all direct and indirect PEs associated with the work and the PE of the service. In contrast, when services are furnished in the facility setting, some costs that would be PEs in the office setting are incurred by the facility. Medicare makes a separate payment to the facility to account for some portion of these costs, and we adjust PEs accordingly under the PFS. As more physician practices become hospital-based, it is difficult to know which PE costs typically are actually incurred by the physician, which are incurred by the hospital, and whether our bifurcated site-of service differential adequately accounts for the typical resource costs given these relationships.

CMS then cited a need to develop data to assess the extent to which this shift toward hospital-based physician practices is occurring. CMS referenced comments collected during the 2014 rulemaking cycle which did not present a consensus regarding the proposed 2014 options.

2015 proposed changes

CMS proposed to begin collecting data on services furnished in off-campus provider-based departments beginning in 2015 by requiring hospitals and physicians to report a modifier for those services furnished in an off-campus, provider-based department on both hospital and physician claims. CMS believes the most efficient and equitable means of gathering this important information across two different payment systems would be to create 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. The modifier would be reported on both the CMS-1500 claim form for physicians' services and the UB-04 (CMS form 1450) for hospital outpatient claims. CMS defined a hospital campus to be the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the CMS regional office.

CMS believes the information collected would be critical in order to develop proposed improvements to PE data or methodology that would appropriately account for the different resource costs among traditional office, facility, and off-campus, provider-based settings.

AAFP recommendations

The AAFP continued to advocate for bringing more equity in payment across sites of service and therefore supported the agency's intent in this area. The AAFP's [letter](#) to CMS in response to the proposed 2014 Medicare physician fee schedule concurred with the Medicare Payment Advisory Commission (MedPAC) recommendation that Medicare seek to pay similar amounts for similar services across payment settings, taking into account differences in the definitions of services and patient severity. This letter also encouraged CMS to consider site-of-service payment parity policies from the opposite perspective. Thus, CMS should not pay significantly more for services in the outpatient setting or Ambulatory Surgical Center (ASC) than in the physician's office. The AAFP encouraged CMS to create incentives for services to be performed in the least costly location, such as a physician's office, rather than in more costly ones, such as the inpatient, outpatient, or ASC settings.

However, AAFP noted that requiring that a new HCPCS modifier be reported with every CMS-1500 claim form for physicians' services and the corresponding form for hospital outpatient claims for services furnished in an off-campus provider-based department of a hospital beginning in 2015 is a

significant change in coding practices for all providers. The AAFP believes this approach is ill-conceived and strongly urged CMS to provide alternatives.

Rather than finalize these proposals, instead the AAFP called on CMS to identify services provided in an off-campus, provider-based setting based on receipt of a corresponding claim for a facility fee from the provider. Doing so would prevent new documentation requirements for providers and also allow CMS contractors to identify off-campus, provider-based settings using existing mechanisms. The AAFP offered to assist CMS in understanding and addressing site-of-service payment discrepancies.

Final policy

CMS will begin to collect data on services furnished in off-campus provider-based departments by requiring hospitals to report a modifier for those services furnished in an off-campus provider-based department of the hospital and by requiring physicians and other billing practitioners to report these services using a new place of service code on professional claims. Data collection will be voluntary for hospitals in 2015 and required beginning on January 1, 2016. The new place of service code will be required for professional claims as soon as it is available, but not before January 1, 2016.

Open Payments

Background

On February 1, 2013, CMS released the final regulation titled "Medicare, Medicaid, Children's Health Insurance Programs; Transparency Reports and Reporting of Physician Ownership or Investment Interests." More commonly referred to as the "Sunshine Act" and rebranded by CMS as the "Open Payments" program, this final regulation implemented the *Affordable Care Act* provision designed to make information publicly available about payments or other transfers of value from certain manufacturers of drugs, devices, biologicals, and medical supplies covered by Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) (defined as "applicable manufacturers") to physicians and teaching hospitals (i.e., "covered recipients").

The law specifies that applicable manufacturers must annually report all payments or transfers of value (including gifts, consulting fees, research activities, speaking fees, meals, and travel) that they make to covered recipients. In addition to reporting on payments, applicable manufacturers also must report ownership and investment interests held by physicians (or the immediate family members of physicians) in such entities.

In this 2013 final rule, CMS stated that they "understand the importance of continuing medical education" and that reporting requirements "should not include compensation for accredited or certified continuing education payments." The regulation discussed that, "Accredited and certified continuing education that complies with applicable standards of the accrediting and certifying entities generally includes safeguards designed to reduce industry influence" and that CMS believes that "reportable payments or transfers of value made to support accredited and certified continuing medical education should remain in a distinct category from unaccredited or non-certified continuing education."

The final rule discusses how CMS received numerous comments that urged CMS to exempt from reporting indirect payments or other transfers of value for education. CMS responded and agreed that "industry support for accredited or certified continuing education is a unique relationship" and that "industry standards for commercial support create important and necessary safeguards prohibiting the involvement of the sponsor in the educational content."

However, CMS believes that even with this separation, the sponsor could still influence the selection of faculty by offering suggestions to the accredited or certified continuing education provider. Although the

continuing education provider may not be required to follow these suggestions, CMS believes that it may often be impossible to distinguish when a suggestion is influential. Therefore, CMS finalized policy that payment made to a speaker at a continuing education program is not an indirect payment or other transfer of value for the purposes of this rule and, therefore, does not need to be reported, when all of the following conditions are met:

- The event at which the covered recipient is speaking meets the accreditation or certification requirements and standards for continuing education of one of the following:
 - The Accreditation Council for Continuing Medical Education (ACCME)
 - The American Academy of Family Physicians
 - The American Dental Association's Continuing Education Recognition Program
 - The American Medical Association
 - The American Osteopathic Association
- The applicable manufacturer does not pay the covered recipient speaker directly
- 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.

2015 proposed changes

Within the 2015 proposed rule, CMS unexpectedly suggested four changes to the Open Payments program:

- Delete the definition of "covered device" as it is duplicative of the definition of "covered drug, device, biological or medical supply," which is already in the regulation.
- Delete the Continuing Education Exclusion in its entirety because eliminating the exemption for payments to speakers at certain accredited or certifying continuing medical education events will create a more consistent reporting requirement for industry and be more consistent for consumers who access reported data.
- Require the reporting of the marketed name of the related covered and non-covered drugs, devices, biologicals, or medical supplies, unless the payment or other transfer of value is not related to a particular covered or non-covered drug, device, biological or medical supply.
- Require applicable manufacturers to report stocks, stock options, or any other ownership interest as distinct categories.

AAFP recommendations

The AAFP strongly disagrees with the CMS proposal to delete the "Continuing Education Exclusion" in its entirety. CMS suggested that this deletion would remove a redundancy from the final rule and expand the range of educational events that are appropriately exempt from reporting. The AAFP stated that deletion of the section would do neither. Moreover, the suggested change would create more confusion and more unintended and unwanted consequences than it purports to resolve. The AAFP urged CMS to specify that certified or accredited CME by the five organizations named in the final rule remain exempt in order to preserve the distinction between certified or accredited CME and other educational programming.

Final policy

Effective for data submitted on and after January 1, 2016, CMS finalized several Open Payment changes in the 2015 final rule:

- CMS deleted its continuing education exclusion in its entirety.
- CMS is requiring manufacturers to report the marketed name and therapeutic area of covered drugs, devices, biologicals, and medical supplies related to each payment.
- If the manufacturer has not yet selected a marketed name, the manufacturer must report the name registered on clinicaltrials.gov.

- Manufacturers may report the names of non-covered drugs, devices, biologicals, and medical supplies relating to payments.
- Manufacturers must indicate if the drug, device, biological, or medical supply is covered or non-covered relating to each payment.
- Manufacturers must report if the payment is unrelated to any covered or non-covered drug, device, biological, or medical supply.
- CMS will require applicable manufacturers to report stocks, stock options, or any other ownership interest as distinct categories.
- CMS also deleted the definition of “covered device” since “covered drug, device, biological or medical supply” is already in the regulation.

Physician Quality Reporting System (PQRS)

Background

The Physician Quality Reporting System (PQRS) is a pay-for-reporting program that uses a combination of incentive payments and penalties to promote reporting of quality information by eligible professionals (EPs). The program provides an incentive payment through 2014 to EPs and group practices that, during the applicable reporting period, satisfactorily report data on quality measures for covered professional services furnished to Medicare Part B fee-for-service beneficiaries or satisfactorily participate in a qualified clinical data registry (QCDR). Beginning in 2015, a downward payment adjustment will apply to EPs who do not satisfactorily report data on quality measures for covered professional services or satisfactorily participate in a QCDR.

2015 proposed changes

CMS proposed updates to the PQRS primarily related to the 2017 PQRS payment adjustment. CMS proposed to add 28 new individual measures and two measure groups to fill existing gaps. CMS proposed to remove 73 measures from reporting for the PQRS. These changes, if finalized, would bring the PQRS individual measure set to 240 total measures. Generally, EPs would need to report nine measures covering three National Quality Strategy domains. CMS also proposed to require that EPs who see at least one Medicare patient in a face-to-face encounter report measures from a newly proposed cross-cutting measures set in addition to any other measures that the EP is required to report.

For those who report as an individual EP and for the 2017 PQRS payment adjustment, CMS criteria for satisfactory reporting and satisfactory participation are generally similar to the criteria finalized for the 2014 PQRS incentive. Additionally, EPs who see at least one Medicare patient in a face-to-face encounter and choose to report PQRS quality measures via claims or registry would be required to report on at least two measures in the newly proposed PQRS cross-cutting measures set.

For those who report as a group practice and for the 2017 PQRS payment adjustment, CMS proposed generally similar criteria to the 2014 PQRS incentive but with the following differences:

- Change the number of patients for which group practices report measures under the GPRO web interface from 411 for group practices with 100+ eligible professionals and from 218 for group practices with 25-99 EPs to 248 for all group practices with 25 or more EPs.
- Group practices that have at least one EP who sees at least one Medicare patient in a face-to-face encounter and that choose to report via registry would be required to report on at least two measures in the proposed PQRS cross-cutting measures set. If these group practices report using a certified survey vendor and a registry, only one measure in the cross-cutting measures set would need to be reported.

CMS still would require EPs to report on the most recent version of electronically specified clinical quality measures (CQMs), and the agency proposed that EPs not be required to ensure that their

Certified EHR Technology (CEHRT) products are recertified to the most recent version of the electronic specifications for the CQMs.

AAFP recommendations

The AAFP supported CMS efforts to align measures across quality programs but expressed concern with the proposal to add two cross-cutting measures. The AAFP noted that the burden of reporting multiple quality measures too often falls disproportionately on primary care physicians.

Final policy

For the 2015 PQRS, CMS is adding 20 new individual measures and two measures groups to fill existing measure gaps. CMS removed 50 measures from reporting for the PQRS. Therefore, the 2015 PQRS individual measure set totals 255 measures. Generally, EPs need only report nine measures covering three National Quality Strategy (NQS) domains.

For the 2017 PQRS payment adjustment, CMS established criteria for satisfactory reporting and satisfactory participation that are generally similar to the 2014 PQRS criteria. However, the final criteria for satisfactory reporting for the 2017 PQRS payment adjustment differs from the established criteria for the 2014 incentive in the following ways. Avoiding a payment penalty in 2017 requires:

- EPs and group practices reporting via claims or registry who see at least one Medicare patient in a face-to-face encounter must report on at least one measure from a newly cross-cutting measures set in addition to any other measures that the EP is required to report.
- All group practices of 25 or more EPs using the GPRO web interface to report measures on a beneficiary sample of 248 patients.
- All group practices of 100 or more EPs that are registered for the GPRO to report on the Consumer Assessment of Healthcare Provider and Systems survey (CAHPS) for PQRS regardless of the reporting mechanism the group practice chooses and the group practices will bear the cost of administering CAHPS for PQRS.

Medicare Shared Savings Program

Background

The Medicare Shared Savings Program was established to facilitate coordination and cooperation among Medicare enrolled providers and suppliers, improve the quality of care for Medicare Fee-for-Service (FFS) beneficiaries, and reduce the rate of growth in health care costs through participation in an Accountable Care Organization (ACO). The 2015 proposed rule includes updates to parts of the Shared Savings Program regulations.

2015 proposed changes

CMS proposed revising the quality scoring strategy to recognize and reward ACOs that make year-to-year improvements in quality performance scores on individual measures by adding a quality improvement measure that adds bonus points to each of the four quality measure domains based on improvement. In response to feedback regarding “topped out” measures, when the national FFS data results in the 90th percentile for a measure are greater than or equal to 95 percent, CMS would use flat percentages for the measure.

CMS also proposed revisions to reflect up-to-date clinical guidelines and practice, reduce duplicative measures, increase focus on claims-based outcome measures, and reduce ACO reporting burden. The total number of measures for quality reporting would increase from 33 to 37 under this proposal. Specifically, new measures would be added to focus on avoidable admissions for patients with multiple chronic conditions, heart failure, and diabetes; depression remission; all cause readmissions to a skilled nursing facility; and stewardship of patient resources.

AAFP recommendations

The AAFP generally agreed with the proposals to better align the Medicare Shared Savings Program with meaningful use group reporting requirements and to refine the quality measures used in establishing quality performance standards. Insofar as the AAFP continues to support the alignment of overlapping reporting requirements for physicians, the AAFP found this alignment proposal to be consistent with AAFP policies.

Final policy

CMS finalized the quality scoring strategy to reward ACOs that make year-to-year improvements in quality performance scores on individual measures by including a quality improvement measure that adds bonus points to each of the four quality measure domains based on improvement. CMS finalized that ACOs can receive up to four points to reward improvements in quality performance, beginning in 2015.

CMS modified the benchmarking methodology for “topped out” measures. CMS will use flat percentages to establish the benchmark for a measure when the national fee-for-service data results in the 90th percentile being greater than or equal to 95 percent.

CMS also made changes to reflect up-to-date clinical guidelines and practice, reduce duplicative measures, increase focus on claims-based outcome measures, and reduce ACO reporting burden. The changes do not affect the total number of measures used in the Shared Savings Program which remains 33. However, CMS increased the number of measures calculated through claims and decreased the number of measures reported by the ACO through the GPRO web interface.

Specifically, new measures will be added to focus on:

- 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.

Physician Compare Website

Background

The *Affordable Care Act* requires that CMS develop a Physician Compare website with information on physicians enrolled in the Medicare program as well as information on other eligible professionals who participate in PQRS. CMS launched the first phase of Physician Compare on December 30, 2010, by posting the names of eligible professionals who satisfactorily submitted quality data for the 2009 PQRS. The law also requires CMS to implement make publicly available through this website data on physician performance that provides comparable information on quality and patient experience measures.

In June of 2013, CMS launched a full redesign of Physician Compare, including a complete overhaul of the underlying database and a new intelligent search feature. Users can now view information about approved Medicare professionals, such as name, primary and secondary specialties, practice locations, group affiliations, hospital affiliations that link to the hospital’s profile on Hospital Compare as available, Medicare Assignment status, education, languages spoken, and American Board of Medical Specialties (ABMS) board certification information. In addition, for group practices, users can also view group practice names, specialties, practice locations, Medicare Assignment status, and affiliated professionals.

2015 proposed changes

The 2015 rule proposed to expand public reporting of group-level measures by making all 2015 PQRS GRPO web interface, registry, and EHR measures for group practices of 2 or more EPs and ACOs available for public reporting on Physician Compare in 2016. CMS proposed this data must meet the minimum sample size of 20 patients and prove to be statistically valid and reliable.

In 2015, CMS proposed to publicly report 20 PQRS individual measures reported in 2013 and collected through a registry, EHR, or claims. All measures submitted, reviewed, and deemed valid and reliable would be reported in the Physician Compare downloadable file; however, not all measures would be included on the Physician Compare profile pages. In addition, CMS proposed including an indicator on Physician Compare for satisfactory reporters under PQRS in 2015, participants in EHR, as well as EPs who report the PQRS Cardiovascular Prevention measures group in support of Million Hearts.

CMS also proposed to publicly report the 2015 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data for PQRS for group practices of two or more EPs who report this data, as well as CAHPS for ACOs that meet the specified sample size requirements and collect data via a CMS-specified CAHPS vendor. This would be publicly reported in 2016. CMS proposed to post on Physician Compare the 2015 QCDR measure data collected at the individual measure level or aggregated to a higher level of the QCDR's choosing. Finally, CMS proposed to give group practices a 30-day preview period before the measures are published on Physician Compare.

AAFP recommendations

The AAFP expressed support for the Physician Compare concept though stated concerns with ensuring that what CMS publishes is actually valid and useful to consumers. The AAFP also stated that the 30-day preview period was too brief and instead urged CMS to provide a preview period of 90 days to give the physician sufficient time to review, validate, and potentially appeal the finding before public reporting.

Final policy

CMS will increase the amount of information about physicians and practices on the Physician Compare website, including quality measure performance for groups and individuals. CMS will expand public reporting of group-level measures by making all 2015 PQRS GPRO web interface, registry, and EHR measures for group practices of two or more EPs and all measures reported by ACOs available for public reporting on Physician Compare in 2016. CMS finalized that this data must meet the minimum sample size of 20 patients and prove to be statistically valid, reliable, comparable, and accurate.

CMS did not finalize the proposal to publicly report 20 PQRS individual measures reported in 2013 and collected through a registry, EHR, or claims in 2015. However, CMS finalized the proposal to expand public reporting of measures for individual EPs by making all 2015 PQRS individual measures collected via registry, EHR, or claims available for public reporting on Physician Compare in late 2016, if technically feasible, with the exception of those measures that are new to PQRS and thus in their first year. In general, no first year measures will be publicly reported on Physician Compare.

CMS finalized the proposal to publicly report 2015 CAHPS survey data in 2016 for PQRS for group practices of two or more EPs who report this data, as well as CAHPS for ACOs, for those that meet the specified sample size requirements and collect data via a CMS-specified CAHPS vendor. CMS finalized the proposal to publicly report individual EP-level QCDR measures with some modifications, including not publishing first year measures.

Physician Value Payment Modifier

Background

The *Affordable Care Act* establishes a value payment modifier that provides for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule based upon the quality of care furnished to Medicare FFS beneficiaries compared to the cost of that care during a performance period. Further, the statute requires that CMS begin applying the value modifier on January 1, 2015, with respect to items and services furnished by specific physicians and groups of physicians and to apply it to all physicians and groups of physicians beginning no later than January 1, 2017. The statute requires that the value modifier must be implemented in a budget neutral manner, generally meaning that positive payment adjustments for high performance must balance the negative payment adjustments applied for poor performance.

2015 proposed changes

CMS proposed additions and refinements to existing value modifier policies to continue its phased-in implementation of the value modifier. CMS proposed to apply the value modifier beginning in 2017 to physicians in groups with two or more eligible professionals (EPs) and to physicians who are solo practitioners. CMS proposed to apply the value modifier beginning in 2017 to non-physician EPs in groups with two or more EPs and to non-physician EPs who are solo practitioners.

CMS estimated that these proposals would affect approximately 83,500 groups and 210,000 solo practitioners (as identified by their Taxpayer Identification Numbers (TINs)) that consist of approximately 815,000 physicians and 315,000 non-physician EPs.

CMS proposed to increase the downward adjustment under the value modifier from -2.0 percent in the 2016 payment adjustment period to -4.0 percent for the 2017 payment adjustment period. That is, for 2017 payments, a -4.0 percent value modifier would apply to groups and solo practitioners subject to the value modifier that do not meet satisfactory quality reporting requirements for PQRS in 2015. In addition, CMS proposed to increase the maximum downward adjustment under the quality-tiering methodology 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 also proposed to increase the maximum upward adjustment under the quality-tiering methodology in the 2017 payment adjustment period to +4.0x ('x' represents the upward payment adjustment factor) 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.

Similar to the approach established for the 2016 value modifier and in a continued effort to align the value modifier with PQRS, CMS proposed to classify groups and solo practitioners subject to the 2017 value modifier using a two-category approach that is based on whether and how groups and solo practitioners participate in the PQRS. CMS previously established 2015 as the performance period for the 2017 payment adjustment period for the value modifier. CMS proposed that Category 1 would include those groups with two or more EPs that meet the criteria for satisfactory reporting of data on PQRS quality measures via the PQRS Group Practice Reporting Option (GPRO) (through use of the web-interface, EHR, or registry reporting mechanism). CMS also proposed to include in Category 1 groups that do not register to participate in the PQRS GPRO in 2015 and in which 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); in lieu of satisfactory reporting, at least 50 percent of the group's EPs may satisfactorily participate in a PQRS-QCDR. CMS would maintain the 50-percent threshold for the 2017 value modifier as the agency expands the

application of the value modifier to all groups and solo practitioners in 2017. Lastly, CMS proposed to include in Category 1 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 2017 PQRS payment adjustment or, in lieu of satisfactory reporting, satisfactorily participate in a PQRS-QCQR.

CMS proposed that Category 2 would include those groups and solo practitioners that are subject to the 2017 value modifier and do not fall within Category 1. As discussed below, for 2017, CMS proposed to apply a -4.0 percent value modifier downward payment adjustment to groups with 2 or more EPs and solo practitioners that fall in Category 2.

In addition, CMS proposed to apply the quality-tiering methodology, which is used for evaluating performance on quality and cost measures for the value modifier, to all groups and solo practitioners in Category 1 for the 2017 value modifier. However, CMS also proposed that groups with between two and nine EPs and solo practitioners would receive only upward or neutral adjustments as determined under the quality-tiering methodology and groups with 10 or more EPs would receive upward, neutral, or downward payment adjustments as determined under the quality-tiering methodology. In other words, groups with between two and nine EPs and solo practitioners that are in Category 1 would be held harmless from any downward adjustments derived from the quality-tiering methodology for the 2017 value modifier.

Beginning with the 2017 payment adjustment period, CMS proposed to apply the value modifier to physicians and non-physician EPs in groups with two or more EPs and to physicians and non-physician EPs who are solo practitioners who participate in an Accountable Care Organization (ACO) under the Medicare Shared Savings Program during the payment adjustment period. CMS proposed to use the PQRS GPRO web-interface measures in determining the quality of care composite for groups and solo practitioners participating in ACOs under the Shared Savings Program in 2017. CMS also proposed to use the "all cause hospital readmissions" measure as calculated for ACOs under the Shared Savings Program for inclusion in the quality composite for the value modifier for these groups and solo practitioners.

Beginning with the 2017 payment adjustment period, CMS proposed to apply the value modifier to physicians and non-physician EPs in groups with two or more EPs and to physicians and non-physician EPs who are solo practitioners that participate in the Pioneer ACO Model, the CPC initiative, or other similar models or CMS initiatives during the relevant performance period. Beginning with the 2017 value modifier and to address two issues that the National Quality Forum Cost and Resource Use Committee raised in its review of the total per capita cost measure, CMS proposed to modify the beneficiary attribution methodology used for the value modifier to allow for more consideration of primary care services furnished by non-physician EPs while maintaining general consistency with the assignment methodology used for the Shared Savings Program. CMS also proposed to reverse the current exclusion of certain Medicare beneficiaries during the performance period.

CMS also proposed to expand the informal inquiry process for the value modifier starting with the 2015 payment adjustment period. CMS would establish a brief period for a group or solo practitioner to request correction of a perceived error made by CMS in the determination of its value modifier payment adjustment.

To help prepare for and understand the value modifier, CMS also proposed to continue to use the annual Quality and Resource Use Reports (QRURs) to explain how the value modifier would affect payment. In the late summer 2014, CMS plans to disseminate QRURs based on 2013 data to all groups of physicians and solo practitioners. These QRURs will contain performance information on the

quality and cost measures used to calculate the quality and cost composites of the value modifier and will show how TINs would fare under the policies finalized for the 2015 value modifier.

For groups of physicians with 100 or more EPs, the 2013 QRUR also will show how a group's payments will be affected by the 2015 value modifier, including any upward, neutral, or downward payment adjustment if the group elected the quality-tiering option.

The QRURs will also include additional information about the TIN's performance on the Medicare Spending per Beneficiary measure, individually-reported PQRS measures, and the specialty-adjusted cost measures.

During the summer of 2015, CMS intends to disseminate QRURs based on 2014 data to all groups and solo practitioners, and the reports would show how TINs would fare under the policies finalized for the 2016 value modifier. CMS encourages groups to access their QRURs once they are available later this summer.

AAFP recommendations

The AAFP appreciated that CMS is holding solo and small group practice physicians harmless in the quality-tiering process since 2017 will be the first year they are subject to the value modifier.

Final policy

Based on 2015 reporting, CMS will apply the value-based payment modifier to all physicians, regardless of group size, and increases the amount of payment at risk for groups with ten or more eligible professionals (EPs) to 4 percent.

CMS finalized the rule for a -4.0 percent value modifier adjustment applicable to physician groups of ten or more subject to the value modifier that do not meet the quality reporting requirements for the PQRS, rather than all groups and solo practitioners.

CMS also increased the maximum upward adjustment for 2017 to four times the upward payment adjustment factor for physician groups of ten or more classified as high quality/low cost. CMS will apply a maximum downward adjustment of -2.0 percent for groups with 2 to 9 EPs or solo practitioners if they do not meet the quality reporting requirements for Physician Quality Reporting System (PQRS).

**TABLE 93: CY 2015 PFS Final Rule with Comment Period Estimated Impact Table:
Impacts of Work, Practice Expense, and Malpractice RVUs**

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
TOTAL	\$88,045	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	\$216	0%	0%	0%	0%
ANESTHESIOLOGY	\$1,993	0%	0%	0%	0%
AUDIOLOGIST	\$60	0%	0%	0%	0%
CARDIAC SURGERY	\$355	0%	0%	-1%	-1%
CARDIOLOGY	\$6,470	0%	0%	0%	0%
CHIROPRACTOR	\$812	0%	0%	-1%	-1%
CLINICAL PSYCHOLOGIST	\$704	0%	-1%	0%	-1%
CLINICAL SOCIAL WORKER	\$522	0%	-1%	0%	-1%
COLON AND RECTAL SURGERY	\$159	0%	0%	0%	0%
CRITICAL CARE	\$287	0%	0%	0%	0%
DERMATOLOGY	\$3,177	0%	-1%	0%	-2%
DIAGNOSTIC TESTING FACILITY	\$715	0%	-2%	0%	-2%
EMERGENCY MEDICINE	\$3,046	0%	0%	1%	1%
ENDOCRINOLOGY	\$457	0%	0%	0%	0%
FAMILY PRACTICE	\$6,107	1%	1%	0%	1%
GASTROENTEROLOGY	\$1,884	0%	0%	0%	0%
GENERAL PRACTICE	\$506	0%	0%	0%	0%
GENERAL SURGERY	\$2,245	0%	0%	0%	0%
GERIATRICS	\$227	1%	1%	0%	1%
HAND SURGERY	\$160	0%	0%	0%	0%
HEMATOLOGY/ONCOLOGY	\$1,811	0%	1%	0%	1%
INDEPENDENT LABORATORY	\$714	-1%	0%	0%	-1%
INFECTIOUS DISEASE	\$652	0%	0%	0%	1%
INTERNAL MEDICINE	\$11,123	1%	1%	0%	1%
INTERVENTIONAL PAIN MGMT	\$678	0%	1%	0%	0%
INTERVENTIONAL RADIOLOGY	\$273	0%	1%	0%	0%
MULTISPECIALTY CLINIC/OTHER PHY	\$84	0%	0%	0%	0%
NEPHROLOGY	\$2,181	0%	0%	0%	0%
NEUROLOGY	\$1,513	0%	0%	0%	0%
NEUROSURGERY	\$740	0%	0%	1%	1%
NUCLEAR MEDICINE	\$49	0%	0%	0%	0%
NURSE ANES / ANES ASST	\$1,186	0%	0%	0%	0%
NURSE PRACTITIONER	\$2,224	0%	0%	0%	1%
OBSTETRICS/GYNECOLOGY	\$696	0%	0%	0%	-1%
OPHTHALMOLOGY	\$5,685	0%	0%	-2%	-2%
OPTOMETRY	\$1,163	0%	0%	-1%	-1%
ORAL/MAXILLOFACIAL SURGERY	\$45	0%	0%	0%	0%
ORTHOPEDIC SURGERY	\$3,672	0%	0%	0%	-1%
OTHER	\$28	0%	0%	-1%	-1%
OTOLARNGOLOGY	\$1,174	0%	0%	0%	0%
PATHOLOGY	\$1,077	-1%	1%	0%	0%
PEDIATRICS	\$59	0%	0%	0%	0%
PHYSICAL MEDICINE	\$1,008	0%	0%	0%	0%
PHYSICAL/OCCUPATIONAL THERAPY	\$2,836	0%	0%	1%	1%
PHYSICIAN ASSISTANT	\$1,565	0%	0%	0%	0%
PLASTIC SURGERY	\$374	0%	0%	-1%	0%
PODIATRY	\$2,001	0%	0%	0%	0%
PORTABLE X-RAY SUPPLIER	\$112	0%	-2%	0%	-2%
PSYCHIATRY	\$1,352	0%	0%	0%	0%
PULMONARY DISEASE	\$1,795	0%	0%	0%	0%
RADIATION ONCOLOGY	\$1,794	0%	0%	0%	0%
RADIATION THERAPY CENTERS	\$57	0%	0%	0%	1%
RADIOLOGY	\$4,523	0%	-1%	0%	-1%
RHEUMATOLOGY	\$541	0%	0%	0%	-1%
THORACIC SURGERY	\$343	0%	0%	-1%	-1%
UROLOGY	\$1,838	0%	0%	0%	0%
VASCULAR SURGERY	\$978	0%	0%	0%	0%

Note: Table 93 shows only the payment impact on PFS services. These impacts use a constant conversion factor and thus do not include the effects of the April 2015 conversion factor change required under current law.