

Summary of payment provisions within the 2015 proposed Medicare physician fee schedule

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Executive Summary

On July 3, the Centers for Medicare & Medicaid Services (CMS) issued a [proposed rule](#) that would update payment policies and rates for services furnished under the Medicare physician fee schedule beginning January 1, 2015. In an AAFP [media statement](#) released after the proposed rule became available, the AAFP expressed disappointment that current law requires CMS to slash Medicare physician payments by 20.9 percent unless Congress intervenes before March 31, 2015. The AAFP continues to call on Congress to repeal the flawed sustainable growth rate (SGR) formula and pass payment reform legislation that builds on the value of the services provided rather than the volume of those services.

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 will be approximately \$42, and the service can be billed no more frequently than once per month per qualified patient.

As part of this regulation's release, CMS issued three fact sheets discussing [overall payment policy proposals](#), outlining changes to the [quality reporting programs](#), and summarizing [proposals on the Value Modifier](#). The AAFP will send CMS extensive regulatory comments on this proposed regulation before the comment period closes on September 2, 2014. The final 2015 Medicare physician fee schedule is expected to be released in November.

Chronic Care Management (CCM) services

Background

In 2013, CMS began coverage of post-discharge, transitional care management (TCM) codes as part of a short term payment strategy that recognizes "primary care and care coordination as critical

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components in achieving better care for individuals, better health for individuals, and reduced expenditure growth.” In a December 3, 2012, letter to CMS, the AAFP and other groups expressed gratitude for creating the TCM codes and urged CMS also to begin Medicare coverage for chronic care management (CCM) services. In a separate letter sent March 18, 2013, the AAFP again joined other groups urging CMS to implement CCM codes within the 2014 MPFS.

In comments during the 2014 rulemaking cycle, the AAFP generally supported the CMS proposal to pay CCM services in 2015 and agreed that resources required to properly provide CCM services to beneficiaries with multiple chronic conditions are not adequately reflected in the existing evaluation and management (E/M) codes. The AAFP called on CMS to value the new CCM codes as a 30-day service, because the AAFP advocates for primary care physicians to receive a monthly care management fee for all beneficiaries who are receiving services from a patient-centered medical home (PCMH). The AAFP also reiterated our concern that the current office/outpatient E/M codes are not adequate for primary care and that CMS needs to create dedicated E/M codes for primary care physicians. The AAFP urged CMS to ramp up and expand the Comprehensive Primary Care (CPC) initiative and pay a risk-adjusted care management fee for all Medicare beneficiaries as part of a blended-payment model for the PCMH.

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

Also within the 2014 rulemaking cycle, CMS finalized that CCM services that requirements to bill Medicare for 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 regardless of the time of day or day of the week.
- Continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.
- Care management for chronic conditions including systematic assessment of 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.
- Creation of a patient-centered care plan document to assure that care is provided in a way that is congruent with patient 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 between and 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.

Proposed Changes

Before discussing the CCM code, CMS first reiterates a commitment to supporting primary care and lists a series of initiatives designed to improve payment for, and encourages long-term investment in, care management services. 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 CPC initiative.

In the 2015 rule, CMS proposes a payment rate of \$41.92 for the CCM code. CMS also proposes that it can be billed no more frequently than once per month per qualified patient.

CMS proposes 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 proposes 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.

For a variety of reasons, CMS did not propose an additional set of standards that must be met in order for practitioners to furnish and bill for CCM services. Instead of proposing a new set of standards applicable to only CCM services, CMS decided to emphasize that certain requirements are inherent in the elements of the existing scope of service for CCM services, and clarify that these must be met in order to bill for CCM services.

In addition to the criteria established in 2014, CMS proposes a new scope of service requirement for electronic care planning capabilities and electronic health records. Specifically, CMS proposes 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 being accessible to those who are furnishing care outside of normal business hours, and that is available to be shared electronically with care team members outside of the practice. Practitioners furnishing CCM services beginning in 2015 would be required to utilize an electronic health record certified to at least 2014 Edition certification criteria.

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, or registered dietitian or nutrition professionals.

In 2002, CMS established an annual process for the public to add or remove 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.

Proposed Changes

CMS proposes 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 service E/M services in the office/outpatient setting (CPT codes 99354 and 99355).
- Annual wellness visit (HCPCS codes G0438 and G0439).

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 on an annual basis. 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.

Proposed Changes

CMS proposes 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 proposes 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 proposes 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 proposes 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.

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 Office of Inspector General's concern that global surgical package payments are misvalued, CMS believes that it should gather more information on the E/M services that are typically furnished with surgical procedures. 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 process of the RUC.

Proposed Changes

CMS proposes 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.

Adjustments to Malpractice RVUs

Background

As required by law, CMS is required to review and, if necessary, adjust MP RVUs no less often than every five years.

Proposed Changes

For 2015, CMS conducted the third review and update of the MP RVUs and proposes new malpractice RVUs for all services. The proposed resource-based MP RVUs are based on updated professional liability insurance premiums and largely parallels methodology used in the 2010 update. The calculation requires using information on specialty specific MP premiums linked to a specific service based upon the relative risk factors of the various specialties that furnish a particular service. Because MP premiums vary by state and specialty, the MP premium information must be weighted geographically and by specialty. CMS discusses including a variety of insurance premium data and using information delineated by surgical and nonsurgical classes. CMS notes that "Some companies provided additional surgical subclasses; for example, distinguishing family practice physicians who furnish obstetric services from those who do not." Table 14 in the proposed rule outlines the CMS proposed Risk Factors by Specialty Type and includes "Family Practice" (specialty code 08) with a non-surgical risk factor of 1.77 and a surgical risk factor of 4.18. "Family Practice w/ OB" (specialty code 08 OB) has a surgical risk factor of 3.95.

CMS then calculates the proposed MP RVUs by following the specialty-weighted approach, which bases the MP RVUs for a given service upon a weighted average of the risk factors of all specialties furnishing the service. CMS claims this approach ensures that all specialties furnishing a given service are accounted for in the calculation of the MP RVUs.

Revisions to Geographic Practice Cost Indices (GPCIs)

Background

CMS is required to develop separate GPCIs to measure resource cost differences among localities compared to the national average for each of the three components (physician work, practice expense, and malpractice) of the fee schedule. The agency must review and adjust as necessary the GPCIs at least every 3 years. CMS completed a review and finalized updated GPCIs in the 2014 final rule. The last GPCI update was implemented over 2 years (2011 and 2012), and CMS phased in half of the latest GPCI adjustment in 2014.

Proposed Changes

For 2015, citing newly available data, CMS proposes to use territory-level wage data to calculate the work GPCI and employee wage component of the PE GPCI for the Virgin Islands.

The 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 proposed GPCIs reflect the elimination of the 1.0 work GPCI floor from April 1, 2015 through December 31, 2015.

Off-Campus Provider-Based Departments

Background

Within the larger discussion on PE RVUs, CMS discusses how they seek a better understanding regarding the growing trend toward hospital acquisition of physician offices and subsequent treatment of those locations as off-campus, provider-based, outpatient departments. CMS discusses how they remain 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 cites a need to develop data to assess the extent to which this shift toward hospital-based physician practices is occurring. CMS references comments collected during the 2014 rulemaking cycle and that commenters did not present a consensus opinion to the proposed 2014 options.

Proposed Changes

CMS proposes 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 defines 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.

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 downward payment adjustments 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.

Proposed Changes

CMS proposes updates to the PQRS primarily related to the 2017 PQRS payment adjustment. CMS proposes to add 28 new individual measures and two measures groups to fill existing measure gaps. CMS proposes to remove 73 measures from reporting for the PQRS. These changes, if finalized, 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 proposes 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 that 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 that report as a group practice and for the 2017 PQRS payment adjustment, CMS proposes 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 proposes 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.

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.

Proposed Changes

CMS proposes 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 proposes 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

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 that satisfactorily submitted quality data for the 2009 PQRS. The law also requires CMS to implement a plan for making publicly available through Physician Compare information on physician performance that provides comparable information on quality and patient experience measures. Lastly, CMS is required to submit a report to the Congress, by January 1, 2015, on Physician Compare development, including information on the efforts and plans to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice. Initial work on this report is underway.

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.

Proposed Changes

The 2015 rule proposes 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 proposes these data must meet the minimum sample size of 20 patients and prove to be statistically valid and reliable.

In 2015, CMS proposes to publicly report 20 PQRS individual measures reported in 2013 and collected through a registry, EHR, or claims. CMS proposes expanding 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. 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 proposes 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 proposes 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. Finally, CMS proposes to make available 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.

Physician Value-based Payment Modifier

Background

The *Affordable Care Act* establishes a value-based payment modifier (Value 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 not later than January 1, 2017. The statute requires that the Value Modifier must be implemented in a budget neutral manner, generally meaning that upward payment adjustments for high performance must balance the downward payment adjustments applied for poor performance.

Proposed Changes

CMS proposes additions and refinements to existing Value Modifier policies in order to continue a phased-in implementation of the Value Modifier. CMS proposes 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 proposes 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 estimates 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 proposes 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 proposes 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 proposes 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 proposes 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 proposes 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, electronic health record (EHR), or registry reporting mechanism). CMS also proposes 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% of the group's EPs may satisfactorily participate in a PQRS-QCQR. 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 proposes 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 proposes 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 proposes 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 proposes 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 proposes 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 proposes 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 an Accountable Care Organization (ACO) under the Medicare Shared Savings Program during the payment adjustment period. CMS proposes 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 proposes 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 proposes 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 Innovation Center 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 proposes 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 proposes to reverse the current exclusion of certain Medicare beneficiaries during the performance period.

CMS also proposes 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 proposes 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 will also 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.

TABLE 60: CY 2015 PFS Proposed Rule Estimated Impact on Total Allowed Charges by Specialty*

(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	\$87,374	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	\$215	0%	0%	0%	0%
ANESTHESIOLOGY	\$1,979	0%	0%	0%	0%
AUDIOLOGIST	\$60	0%	0%	-1%	-1%
CARDIAC SURGERY	\$351	0%	0%	-1%	-1%
CARDIOLOGY	\$6,420	0%	0%	0%	1%
CHIROPRACTOR	\$803	0%	0%	-1%	-1%
CLINICAL PSYCHOLOGIST	\$695	0%	-1%	0%	-1%
CLINICAL SOCIAL WORKER	\$514	0%	-1%	0%	-1%
COLON AND RECTAL SURGERY	\$158	0%	0%	0%	0%
CRITICAL CARE	\$285	0%	0%	0%	1%
DERMATOLOGY	\$3,162	0%	0%	0%	0%
DIAGNOSTIC TESTING FACILITY	\$705	0%	-2%	0%	-2%
EMERGENCY MEDICINE	\$3,024	0%	0%	1%	1%
ENDOCRINOLOGY	\$455	0%	0%	0%	0%
FAMILY PRACTICE	\$6,061	1%	1%	0%	2%
GASTROENTEROLOGY	\$1,875	0%	0%	0%	0%
GENERAL PRACTICE	\$498	0%	0%	0%	0%
GENERAL SURGERY	\$2,222	0%	0%	0%	0%
GERIATRICS	\$224	1%	1%	0%	1%
HAND SURGERY	\$159	0%	0%	0%	0%
HEMATOLOGY/ONCOLOGY	\$1,803	0%	1%	0%	1%
INDEPENDENT LABORATORY	\$703	0%	3%	0%	3%
INFECTIOUS DISEASE	\$647	0%	0%	0%	1%
INTERNAL MEDICINE	\$11,026	1%	1%	0%	2%
INTERVENTIONAL PAIN MGMT	\$672	0%	1%	0%	1%
INTERVENTIONAL RADIOLOGY	\$270	0%	-1%	0%	-1%
MULTISPECIALTY CLINIC/OTHER	\$83	0%	0%	0%	1%
NEPHROLOGY	\$2,167	0%	0%	0%	0%
NEUROLOGY	\$1,502	0%	0%	0%	0%
NEUROSURGERY	\$733	0%	0%	1%	1%
NUCLEAR MEDICINE	\$48	0%	0%	0%	1%
NURSE ANES / ANES ASST	\$1,177	0%	0%	0%	0%
NURSE PRACTITIONER	\$2,201	0%	0%	0%	1%
OBSTETRICS/GYNECOLOGY	\$690	0%	0%	0%	0%
OPHTHALMOLOGY	\$5,663	0%	0%	-2%	-2%
OPTOMETRY	\$1,152	0%	1%	-1%	0%
ORAL/MAXILLOFACIAL SURGERY	\$44	0%	0%	0%	0%
ORTHOPEDIC SURGERY	\$3,649	0%	0%	0%	0%
OTHER	\$27	0%	0%	-1%	-1%
OTOLARNGOLOGY	\$1,167	0%	0%	0%	0%
PATHOLOGY	\$1,067	0%	1%	0%	1%
PEDIATRICS	\$58	0%	0%	0%	0%
PHYSICAL MEDICINE	\$998	0%	0%	0%	0%
PHYSICAL/OCCUPATIONAL THERAPY	\$2,806	0%	0%	1%	1%
PHYSICIAN ASSISTANT	\$1,553	0%	0%	0%	1%
PLASTIC SURGERY	\$368	0%	0%	-1%	0%
PODIATRY	\$1,979	0%	0%	0%	0%
PORTABLE X-RAY SUPPLIER	\$109	0%	-3%	0%	-3%
PSYCHIATRY	\$1,330	0%	0%	0%	0%
PULMONARY DISEASE	\$1,784	0%	0%	0%	0%
RADIATION ONCOLOGY	\$1,796	0%	-4%	0%	-4%
RADIATION THERAPY CENTERS	\$60	0%	-8%	0%	-8%
RADIOLOGY	\$4,497	0%	-1%	0%	-2%
RHEUMATOLOGY	\$538	0%	0%	0%	0%
THORACIC SURGERY	\$340	0%	0%	0%	0%
UROLOGY	\$1,829	0%	0%	0%	0%
VASCULAR SURGERY	\$970	0%	0%	0%	1%

*Table 60 shows only the payment impact on PFS services and does not include the effects of the change in the CF scheduled to occur on April 1, 2015 under current law.

** Column F may not equal the sum of columns C, D, and E due to rounding.