



## **AAO-HNS SUMMARY OF CY 2015 PROPOSED MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)**

On July 3, 2014, the Centers for Medicare & Medicaid Services (CMS) posted the proposed rule for payments in the Medicare physician fee schedule (MPFS) for calendar year (CY) 2015. In addition to payment policy, payment rate updates, CMS quality initiative program incentives and penalties (PQRS, Value Based Payment Modifier, and EHR incentive programs) the MPFS addresses a number of provisions of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (referred to as the “Affordable Care Act” or ACA) and the America Taxpayer Relief Act of 2012. *CMS will accept comments on the 2015 proposed rule during a 60 day comment period which concludes at 5pm ET on September 2, 2013. The Academy plans to submit*

### **Important Otolaryngology-Head and Neck Surgery policies addressed by CMS:**

#### **1) Medicare Sustainable Growth Rate (SGR):**

CMS projects that the CF for the first three months of CY 2015 would be \$35.7977 (compared to the 2014 conversion factor of \$35.8228). This estimate is based on a zero percent update (through March 31, 2015, as provided under the Protecting Access to Medicare Act of 2014 (PAMA) and the adjustments necessary to maintain budget neutrality for the policies in this proposed rule. CMS applies this CF to all of CY 2015 for purposes of completing its regulatory impact analysis, however, absent further Congressional action, a Medicare Sustainable Growth Rate (SGR)-induced reduction of over 20% would occur on April 1, 2015.

#### **2) Estimated Overall Impact on Total Allowed Charges for ENT Services (Table 60)**

Based on the [Impact table](#) found in the proposed rule (Table 60), the following impacts for ENT, Allergy, Plastic Surgery, Audiology, and Oral/Maxillofacial surgery are estimated under the MPFS in 2015. **It is important to note that these estimates DO NOT INCLUDE the proposed reduction attributable to the SGR absent a Congressional fix prior to January 1, 2015 and are not necessarily reflective of changes that may occur among families of codes within any given specialty designation.**

#### **3) Practice Expense (p. 26)**

##### **Using OPPS and ASC Rates in Developing PE RVUs**

Within the proposed rule, CMS revisits their CY 2014 proposed policy to limit the nonfacility PE RVUs for individual codes so that the total nonfacility PFS payment amount would not exceed the total combined amount that Medicare would pay for the same code in the facility setting. CMS adds that it is not proposing a similar policy for the CY 2015 PFS and that if it did do so in the future rulemaking, it would consider all of the comments received previously. *CMS notes, however, that it continues to believe that there are various possibilities for leveraging the use of available hospital cost data in the PE RVU methodology to ensure that the relative costs for PFS services are developed using data that is auditable and comprehensively and regularly updated.* CMS adds that section 220(a) of PAMA, Publ. L. 113-93, provides them with the authority to exploring ways of collecting better and updated resource data from physician practices, including those that are provider-based, and other non-facility entities paid under the PFS, and that using this information does not detract from the statutorily required “relativity” of the MPFS. CMS says that such efforts will be challenging given the wide variety of practices and likely impose some burden on EPs. CMS notes that through a validation contract, it has been gathering time data directly from physician practices, from which it has learned much about the challenges of gathering data directly from physician practices.

CMS further notes that section 220 of PAMA provides authority to use alternative approaches to establish PE RVUs, including the use of data from other suppliers and providers, and that the agency is exploring how best to exercise this authority. *CMS seeks comment on the possible uses of the Medicare hospital outpatient cost data in potential revisions of the PFS PE methodology, as means to validate or, perhaps, in setting the relative resource cost assumptions within the PFS PE methodology. CMS is particularly interested in comments identifying other broad-based, auditable, mechanisms for data collection.*

##### **Collecting Data on Off-Campus Provider-Based Outpatient Departments**

CMS also continues to 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 adds that 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 Medicare’s bifurcated site-of-service differential adequately accounts for the typical resource costs given these relationships. *CMS proposes to adopt one of their policy proposals from last year’s rulemaking, 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, but nonetheless invites additional comment on whether such a modifier is the best mechanism for collecting service-level information.* 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 proposes to begin collecting this information on January 1, 2015.

#### **4) Potentially Misvalued Services Under the Fee Schedule (p. 67)**

In recent years CMS and the AMA Relative Update Committee (RUC) have taken increasingly significant steps to address potentially misvalued codes. Most recently, section 1848(c)(2)(K)(ii) of the Act (as added by section 3134 of the ACA directed the Secretary to specifically examine potentially misvalued services in seven categories:

- (1) Codes and families of codes for which there has been the fastest growth,
- (2) Codes or families of codes that have experienced substantial changes in practice expenses,
- (3) Codes that are recently established for new technologies or services,

- (4) Multiple codes that are frequently billed in conjunction with furnishing a single service,
- (5) Codes with low relative values, particularly those that are often billed multiple times for a single treatment,
- (6) Codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'), and
- (7) Other codes determined to be appropriate by the Secretary.

In CY 2013, CMS finalized their policy to allow public nomination of potentially misvalued codes which should be considered for review. Within the 2015 proposed rule two codes were nominated by the public as potentially misvalued / requiring review. Notably, one was CPT 41530 Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session, which was nominated by the Academy during 2014 notice and comment periods. The Academy felt that based on input from members and review by experts of the Sleep Committee and other stakeholders that two of the practice expense inputs in the existing code had become outdated and required refinement based on current pricing and technology utilized for this procedure.

Further, CMS proposes a new screen which captures approximately 65 codes listed below as potentially misvalued codes as a prioritized subset of codes that account for the majority of spending under the physician fee schedule. Specifically, they note that within their usual identification process for capturing potentially misvalued codes it is possible to miss certain services that are important to a segment of Medicare practitioners and beneficiaries because the specialty that typically furnishes the service does not have high volume relative to the overall PFS utilization. To capture such services in developing this list, they began by identifying the top 20 codes by specialty in terms of allowed charges. They excluded codes from our proposed potentially misvalued list that we have reviewed since CY 2009, with fewer than \$10 million in allowed charges, and that describe anesthesia or E/M services. They believe that a review of the codes in Table 10 is warranted to assess changes in physician work and to update direct PE inputs since these codes have not been reviewed since CY 2009 or earlier. Furthermore, since these codes have significant impact on PFS payment at the specialty level, a review of the relativity of the codes is essential to ensure that the work and PE RVUs are appropriately relative within the specialty and across specialties, as discussed previously. For these reasons, CMS proposes the codes listed in Table 10 as potentially misvalued. The codes relevant to Otolaryngology are listed below in the abbreviated table:

**TABLE 10: Proposed Potentially Misvalued Codes Identified Through High Expenditure Specialty Screen**

11100 Biopsy skin lesion
11101 Biopsy skin add-on
14060 Tis trnfr e/n/e/l 10 sq cm/<
31575 Diagnostic laryngoscopy
31579 Diagnostic laryngoscopy
92557 Comprehensive hearing test
95004 Percut allergy skin tests
95165 Antigen therapy services

**5) Valuing New, Revised and Potentially Misvalued Codes (p. 151)**

In the CY 2012 rulemaking process, CMS proposed and finalized consolidation of the five-year review and the potentially misvalued code activities into an annual review of potentially misvalued codes. Under this process, CMS issues interim final RVUs for all revaluations and new codes in the PFS final rule with comment period and payments are based on those values during the CY covered by the final rule. CMS considers it appropriate to establish interim values for new, revised and potentially misvalued codes because of the timing incongruities between the PFS rulemaking cycle and the release of codes by the AMA CPT Editorial Panel and the RUC review process.

CMS notes that their recent revaluation of several code families have raised concerns from stakeholders with the existing process based on the reductions in payment for those services. Specifically, that they did not receive notice of the possible reductions before they occurred, CMS notes that stakeholders should be aware of changes because either CPT has made changes or CMS has identified the codes as potentially misvalued, and representatives of the affected specialties are participating in the RUC meetings. Commenters have asserted, however, they are not aware of RUC recommendations, they have no opportunity to respond to RUC recommendations and not all suppliers are permitted to participate in the RUC process. Additionally, some stakeholders objected to interim final decisions because they do not have an opportunity to meaningfully comment before the values are implemented in the next year's final rule.

**Proposal to Modify the Process**

CMS proposes the following:

- Include proposed values for all codes for which CMS has complete RUC recommendations by January 15th of the preceding year.
  - For the CY 2016 rulemaking process, CMS would include in the proposed rule proposed values for all services for which they have a RUC recommendation by January 15, 2015.
- For codes where CMS does not receive a RUC recommendation by January 15th of a year, CMS would delay revaluing the code for one year (or until they receive the RUC recommendation for the code) and include proposed values in the following year's rule.
  - CMS notes there might be some circumstances where the RUC recommendation is received by January 15th but CMS is not able to propose values in that year's proposed rule and CMS would treat these codes as if they had not received recommendations before January 15th.
  - CMS proposes to adopt coding policies and payment rates that conform, to the extent possible, to the policies and rates in place for the previous year.

- For codes that were revised or deleted as part of the annual CPT coding change and when the changes would affect the value of a code, CMS proposes to create G-codes to describe the predecessor codes. If CPT code revisions did not affect the resource inputs, CMS proposes to use the revised codes and continue to pay at the same rate.
- For new codes that describe completely new services, CMS proposes to work with the RUC to ensure recommendations are received in time to include proposed values in the proposed rule. If RUC recommendations were not received in time and CMS determines it is in the public interest to use a new code, CMS proposes to establish values for the code's initial year using the current policy of considering RUC recommendations if available for the final rule and proposing interim final values. CMS also notes that when it would not be appropriate to establish interim final values, CMS would have contractors price the code for the initial year.

### **Refinement Panels**

Given that these proposals would allow for full notice and comment via the proposed rule, CMS states that the need for continued refinement panels would be alleviated in the event this policy is finalized. Thus, CMS is proposing to eliminate the refinement panel process.

### **6) Improving Valuation of the Global Surgical Package – Concerns with 010 and 090 Globals (p. 92)**

Within the 2015 NPRM, CMS proposes a major change to reporting global surgical procedures by suggesting a two year transition of all 010 and 090 global services to a 000 global. Specifically, they note their belief that in the context of the misvalued code initiative, they believe it is critical for the RVUs used to develop PFS payment rates reflect the most accurate resource costs associated with PFS services. As such, CMS does not believe that maintaining the post-operative 10- and 90-day global periods is compatible with their continued interest in using more objective data in the valuation of PFS services and accurately valuing services relative to each other. Because the typical number and level of post-operative visits during global periods may vary greatly across Medicare practitioners and beneficiaries, they believe that continued valuation and payment of these face-to-face services as a multi-day package may skew relativity and create unwarranted payment disparities within PFS payment. They also believe that the resource based valuation of individual physicians' services will continue to serve as a critical foundation for Medicare payment to physicians, whether through the current PFS or in any number of new payment models. Therefore, they feel it is critical that the RVUs under the PFS be based as closely and accurately as possible on the actual resources involved in furnishing the typical occurrence of specific services.

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

- Increase the accuracy of PFS payment by setting payment rates for individual services based more closely upon the typical resources used in furnishing the procedures;
- Avoid potentially duplicative or unwarranted payments when a beneficiary receives post-operative care from a different practitioner during the global period;
- Eliminate disparities between the payment for E/M services in global periods and those furnished individually;
- Maintain the same-day packaging of pre- and post-operative physicians' services in the 0-day global; and
- Facilitate availability of more accurate data for new payment models and quality research.

As they transition these codes, CMS acknowledges they will need to establish RVUs that reflect the change in the global period for all the codes currently valued as 10- and 90-day global surgery services. CMS notes that if they adopt this proposal, they intend to monitor any changes in the utilization of E/M visits following its implementation and seeking comment on potential payment policies that will mitigate such a change in behavior.

CMS notes that given their proposed timeline, it does not seem practical to survey time and intensity information on each of these procedures. Absent any new survey data regarding the procedures themselves, we believe that data regarding the number and level of post-service office visits can be used in conjunction with other methods of valuation, such as:

- Using the current potentially misvalued code process to identify and value the relatively small number of codes that represent the majority of the volume of services that are currently reported with codes with post-operative periods, and then adjusting the aggregate RVUs to account for the number of visits and using magnitude estimation to value the remaining services in the family;
- Valuing one code within a family through the current valuation process and then using magnitude estimation to value the remaining services in the family;
- Surveying a sample of codes across all procedures to create an index that could be used to value the remaining codes.

### **7) Malpractice RVUs (p. 117)**

Section 1848(c)(2)(B)(i) of the SSA requires CMS to review, and if necessary adjust, RVUs no less often than every 5 years. In CY 2015, CMS proposes to implement their third comprehensive review of malpractice (MP) RVUs. The proposed MP RVUs were calculated by a CMS contractor based on updated MP premium data obtained from state insurance rate filings. The calculation requires using information on specialty-specific MP premiums linked to a specific service based on the relative risk factors of the specialties that furnish a particular service. MP premium information is weighted geographically and by specialty to account for variations by state and specialty. CMS used three data sources: CY 2011 and 2012 premium data; 2013 Medicare payment and utilization data; and 2015 proposed work RVUs and geographic practice cost indices (GPCIs). CMS describes the steps for calculating the proposed MP RVUs to include the following: (1) compute a preliminary national average premium for each specialty; (2) determine which premium class(es) to use within each specialty; (3) calculate a

risk factor for each specialty; (4) calculate malpractice RVUs for each HCPCS code; and (5) rescale for budget neutrality so that the total proposed resource-based MP RVUs equal the total current resource-based MP RVUs. CMS says that, on average, work represents about 50.9 percent of payment for a service under the PFS, PE about 44.8 percent, and MP about 4.3 percent.

#### **8) Validating RVUs of Services (p. 74)**

Under the ACA, the Secretary is directed to validate a sampling of RVUs for services identified by the seven categories listed above. *In the CY 2013 proposed rule CMS informed the public of their intent to, “enter into a contract to assist them in validating RVUs of potentially misvalued codes that will explore a model for the validation of physician work under the PFS, both for new and existing services.”* Both contracts will extend over a 2 year period. More details were released regarding these contracts in the 2015 NPRM, including the first interim report from the Urban Institute. The RAND Corporation will use available data to build a validation model to predict work RVUs and the individual components of work RVUs, time and intensity. The model design will be informed by the statistical methodologies and approach used to develop the initial work RVUs and to identify potentially misvalued procedures under current CMS and AMA RUC processes. RAND will use a representative set of CMS-provided codes to test the model. RAND will consult with a technical expert panel on model design issues and the test results. Urban Institute will focus on the central role of time in establishing work RVUs and the concerns that have been raised about the current time values. A key focus of the project is collecting data from several practices for services selected by the contractor. The data will be used to develop time estimates. Urban Institute will use a variety of approaches to develop objective time estimates, depending on the type of service, which will be a very resource-intensive part of the project. Objective time estimates will be compared to the current time values used in the fee schedule. The project team will then convene groups of physicians from a range of specialties to review the new time data and their potential implications for work and the ratio of work to time. Additional detail on both projects can be found here.

#### **9) Payment for Secondary Interpretation of Images (P.191)**

CMS says that questions have arisen as to whether and under what circumstances it would be appropriate for Medicare to permit payments under the PFS when physicians furnish subsequent interpretations of existing radiology images. Under current policy, Medicare can pay for a second interpretation (which is billed using modifier -77) under “unusual circumstances (for which documentation is provided).” *CMS seeks comment to assess whether there is an expanded set of circumstances under which it would be appropriate to allow more routine Medicare payment for a second professional component for radiology services, and whether such a policy would be likely to reduce the incidence of duplicative advanced imaging studies.*

*CMS adds that it welcomes input on any additional considerations*, and says that upon reviewing the comments received, it will consider whether any further action is appropriate, such as proposing under future rulemaking to allow for payment of subsequent interpretations of advanced diagnostic images in lieu of duplicative studies.

#### **10) Removal of Employment Requirements for Billing “Incident To” for Rural Health Clinic and Federally Qualified Health Center Visits (p. 212)**

To provide RHCs and FQHCs with as much flexibility as possible to meet their staffing needs, CMS proposes to revise existing regulations (in several places) to remove the requirement that services furnished incident to an RHC or FQHC visit must be furnished by an employee of the RHC or FQHC to allow nurses, medical assistants, and other auxiliary personnel to furnish “incident to” services under contract in RHCs and FQHCs. CMS says this proposal would involve no cost to the federal government, and adds that it cannot estimate a cost savings for RHCs and FQHCs.

#### **11) Physician Compare Website (p. 246)**

Under the ACA, CMS was required to develop, no later than January 1, 2011, a Physician Compare Internet website with information physicians enrolled in the Medicare program. The Act also requires that no later than January 1, 2013, CMS make a plan publicly available that will allow information on physician performance related to quality and patient experience measures. This includes requirements to make the information posted reliable and statistically valid, as well as ensuring that physicians whose information is posted have a reasonable opportunity to review their results before posting the information online. This will consist of a 30-day previous period for all measurement performance data before it is publicly available. In addition, by 2015 CMS must submit a report to Congress updating them on the status of the website development and include information on 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.

CMS released a redesigned Physician Compare website which can be found here: [www.medicare.gov/physiciancompare](http://www.medicare.gov/physiciancompare). Information that is currently reflected on the site includes address, education and ABMS board certification information, hospital affiliations, and language skills. CMS is required to post the names of EPs who satisfactorily report under PQRS as well as those who are successful e-prescribers under the Medicare eRx Incentive Program. This information is reflected by links on the website. CMS states that all information posted on the website is derived from the PECOS system, and is verified by claims.

**In future years, CMS proposes the following additional information be posted to the website and the agency seeks comment on the following proposals:**

- (1) Publicly reporting 20 2013 PQRS individual measures collected through a Registry, EHR, or claims mirroring measures finalized for 2014;
- (2) Publicly reporting *ALL* 2015 PQRS measures for individual EPs collected through a Registry, EHR, or claims;
- (3) Publicly reporting *ALL* 2015 PQRS Group Practice Reporting Option (GPRO) measures reported via the Web Interface, EHR, and Registry for group practices of 2 or more EPs and all measures reported by ACOs with a minimum sample size of twenty patients;
- (4) Publicly reporting an indicator for satisfactory reporters under PQRS and PQRS GPRO, participants in EHR, and EPs who report the PQRS Cardiovascular Prevention measures group in support of Million Hearts;

- (5) Publicly reporting 2015 CAHPS for PQRS for groups of 2 or more EPs and CAHPS for ACOs for those who meet the specified sample size requirements and collect data via a CMS-specified certified CAHPS vendor;
- (6) Publicly reporting *ALL* 2015 Qualified Clinical Data Registry (QCDR) measure data collected at the individual level or aggregated to a higher level of the QCDR's choosing (QCDR would be required to declare during its self-nomination if it plans to post data on its own website and allow Physician Compare to link to it or if the QCDR will provide data to CMS for public reporting on Physician Compare);
- (7) Publicly reporting in 2016 benchmarks for 2015 PQRS GPRO data using the same method currently utilized under the Medicare Shared Savings Program (i.e. calculate benchmarks using data at group practice TIN level for all providers with at least twenty cases in the denominator and using a 30th to 90th percentile range); and
- (8) Publicly reporting in CY 2016 patient experience data from 2015 for all group practices of 2 or more (12 summary survey measures previously finalized for 2014 data).

**12) Physician Quality Reporting System (PQRS) (p. 267)**

For background and information on who is eligible to participate in PQRS, visit the Academy's website and fact sheets at <http://bit.ly/entPQRS>. The proposed rule primarily focuses on CMS proposals related to the 2017 Physician Quality Reporting System (PQRS) payment adjustment, which will be based on an EP's (EPs) or a group practice's reporting of quality measures data during the *12-month calendar year reporting period occurring in 2015* (that is, January 1 through December 31, 2015). *The PQRS payment adjustment for 2016 and subsequent years for failure to meet the PQRS reporting requirements for the applicable reporting period is -2 percent.*

**Criteria for Satisfactory Individual Reporting in 2017 (2015 performance year)**

CMS made several changes to the criteria for satisfactory individual reporting for performance year (PY) 2015. A summary of these changes can be [found here](#). A key change for 2015 is that CMS is now requiring individuals reporting via qualified registry (PQRS Wizard) and Groups reporting via the GPRO reporting options to report on 2 of the new cross-cutting measures in addition to other reporting requirements if they see at least 1 Medicare patient in a face-to-face encounter (defined as a surgical procedure or general office visit/outpatient visit etc.).

**Proposed Changes to Measures in CY 2015**

<u>Proposed New Individual Measures</u>	<u>Proposed Measures for NQS Domain Change</u>	<u>Proposed Measures for Deletion</u>	<u>Proposed Changes to how Measures Can be Reported</u>	<u>Proposed Changes to Measure Groups</u>	<u>Proposed Changes to GRPO Measures</u>
CMS is proposing to ADD 28 measures in CY 2015. Listed in Table 22.	CMS is proposing to change the NQS Domain for 24 measures. Listed in Table 23.	CMS is proposing to DELETE 73 measures. Listed in Table 24.	CMS is proposing to change the way 56 measures are reported. Listed in Table 25.	CMS is proposing to increase the number of measures form 4 to 6 in measure groups and as a result of Academy Advocacy is <b>adding 2 new measures groups: Sinusitis and AOE;</b> and delete 6 measure groups, including sleep apnea and perioperative care.	CMS is proposing to remove 5 existing measures (listed in Table 48 of the proposed rule) and add 9 new measures (listed in Table 49 of the proposed rule).

**Changes to Individual Reporting Requirements**

**Reporting via Claims:** CMS is not proposing to make changes to the claims-based reporting mechanism.

**Changes for Reporting via Qualified Registry (PQRS Wizard):**

- o For the qualified registry reporting mechanism, CMS proposes to require a qualified registry to be able to collect needed data elements and transmit to CMS the data at the Tax Identification Number (TIN)/National Provider Identifier (NPI) level for **all 18 cross-cutting measures** specified in [Table 21](#) of the proposed rule for which the registry's participating EPs are able to report.<sup>2</sup>
- o *CMS is proposing to require that an EP or group practice who sees at least 1 Medicare patient in a face-to-face encounter (e.g. E/MS and surgical procedures) to report on at least 2 cross-cutting PQRS measures (in addition to meeting other reporting requirements).* CMS says it is proposing to require the ability to report all cross-cutting measures of relevance to a qualified registry's participating EPs because this would give these EPs the flexibility to choose which 2 cross-cutting measures to report.
- o For the qualified registry reporting mechanism, CMS is also proposing to push back the reporting deadline from the last Friday of February to March 31 (for example, March 31, 2016 for the reporting periods ending in 2015). *CMS seeks comment on whether to propose in future rulemaking to allow more frequent submissions of data, such as quarterly or year-round submissions, rather than having only one opportunity to submit data as is the current process.*

### **Changes for Reporting via EHR:**

- If reporting via direct electronic health record (EHR) and EHR data submission vendor products that are certified electronic health record technology (CEHRT), CMS notes that updated implementation guides for data file formats for 2015, when available, will be posted at <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms>. These implementation guides will describe the technical requirements for data submission, which CMS proposes to continue to apply to direct EHR products and EHR data submission vendor products for 2015 and beyond.
- For 2015 and beyond, CMS also proposes to have the EP or group practice provide the CMS EHR Certification Number of the product used. As it does for the qualified registry reporting mechanism, *CMS seeks comment on whether to allow more frequent submission of PQRS data in the future.*

### **Changes to Group Practice Reporting Option**

With respect to the Group Practice Reporting Option (GPRO), CMS proposes an earlier deadline for registering to participate in the GPRO, June 30 of the year in which the reporting period occurs (that is, June 30, 2015, for reporting periods occurring in 2015), rather than the current September 30. This is being proposed because CMS believes there is benefit in providing timelier feedback reports. *CMS seeks comment on whether to allow more frequent submissions of data through the GPRO Web interface.*

### **Changes to PQRS Quality Measures for 2015 and Beyond**

CMS notes that it is proposing to drop some PQRS measures because the measure owner/developer has indicated that it will not be able to maintain the measure. **However, CMS says that if it learns that a certain measure owner/developer is able to maintain a measure, or another entity is able to maintain the measure in a manner that allows the measure to be available for reporting under the PQRS for the CY 2017 PQRS payment adjustment, CMS proposes to keep the measure.** Similarly, if, after display of this proposed rule, CMS discovers additional measures within the current PQRS measure set that a measure owner/developer can no longer maintain, it proposes to remove these measures from the PQRS measure set beginning in 2015.

CMS also notes that it is beginning to group the final measures available for reporting according to specialty and refers readers to the current listing of measures by specialty at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>. CMS emphasizes that EPs are not required to report measures according to these suggested groups of measures. CMS adds that it plans to have a measure subset that specifically addresses multiple chronic conditions.

**[Click here to access CMS slides on 2015 changes to the PQRS program](#)**

### **13) Value Based Payment Modifier (VBM) and Physician Feedback Reporting Program (p. 442)**

Beginning **January 1, 2015**, CMS is required to apply a value-based payment modifier (VBM) to specific physicians and groups of physicians under the PFS. In 2013, CMS finalized the decision to initially apply the VBM to all groups of physicians, identified by a single TIN, with 100 or more EPs (EPs) (physician, practitioner, therapist, speech-language pathologist, or audiologist). CMS had previously finalized CY 2013 as the initial performance period for the VBM that will be applied in CY 2015, and they propose that performance in CY 2015 will be used to calculate the payment modifier applied in CY 2016. **In CY 2017, CMS will apply the VBM to all physicians, nonphysicians, and groups of physicians, regardless of group size.**

### **Proposals for the VM**

As discussed below in greater detail, CMS makes the following proposals for the VM:

- Apply the VM to all physicians and nonphysician EPs in groups with 2 or more EPs and to solo practitioners starting in CY 2017.
- Make quality-tiering mandatory for groups and solo practitioners with Category 1 for the CY 2017 VM. **Groups with 10 or more EPs would be subject to upward, neutral, or downward adjustments. Groups with between 2 and 9 EPs and solo practitioners would be subject to only an upward or neutral adjustment.**
- Apply the VM to physicians and nonphysician EPs participating in the Shared Savings Program, the Pioneer ACO Model, the CPC Initiative, or other similar CMS initiatives starting in CY 2017.
- Clarifies the exclusion of non-assigned claims for non-participating providers from the VM.
- **Increase the amount of payment at risk under the VM from -2.0 percent in CY 2016 to -4.0 percent in CY 2017. When combined with the PQRS penalty, this would total a -6 percent penalty for all quality reporting.**
- Align the quality measures and quality reporting mechanisms for the VM with those available to groups and individuals under the PQRS during the CY 2015 performance period.
- Expand the current informal inquiry process to allow additional corrections for the CY 2015 payment adjustment period.
- Address the concerns raised by NQF regarding the per capital cost measures in the cost composite
- **CMS also seeks comment about how to include hospital-based physicians in the VM.**

### **Group Size & Definitions**

CMS proposes that beginning with CY 2017, the VM would be applied to physician and nonphysician EPs in groups with 2 or more EPs and to solo practitioners based on the CY 2015 performance period.

- **Physicians are defined as:** doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors.

- **EP are defined** as any of the following: (1) a physician; (2) a practitioner described in section 1842(b)(18)(C) of the Act: physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse mid-wife, clinical social worker, clinical psychologist, registered dietician, or nutritional professional; (3) a physical or occupational therapist or qualified speech-language pathologist; or (4) a qualified audiologist.
- **CMS will define a group of physicians as** a single TIN with 2 or more EPs, as identified by their individual NPI and have reassigned their Medicare billing rights to the TIN. During the payment adjustment period, all the nonphysician EPs who bill under a group’s TIN would be subject to the same VM that would apply to the physicians who bill under the TIN.
- **CMS will define a solo practitioner as** a single TIN with 1 EP as identified by an individual NPI billing under the TIN.

**Application of the VM to Nonphysician EPs**

CMS proposes that beginning with CY 2017, the VM would be applied to groups that consist of only nonphysician EPs and to solo practitioners who are nonphysician EPs based on the CY 2015 performance period.

- CMS proposes that physicians and nonphysician EPs would be subject to the same VM policies established in earlier rulemakings
- The quality of care composite would be based on the quality data submitted under the PQRS at the group or individual level
- The cost composite would be based on the beneficiary attribution methodology and if a cost composite cannot be calculated for a group or solo practitioner, CMS proposes to classify the group or solo practitioner’s cost composite as “average”.

**Physician Feedback Program / Quality Resource Use Reports (QRURs)**

CMS plans in late summer, to disseminate QRURs based on CY 2013 data to all physicians. CMS notes these reports will contain performance on the quality and cost measures used to score the cost and quality composites for the VM. **The ACA requires the Secretary to develop an episode grouper and include episode-based costs in the QRURs. An episode of care consists of medical and/or procedural services that address a specific medical condition or procedure that are delivered to a patient in a defined time period and are captured by claims data. An episode grouper organizes administrative claims data into episodes.**

In the proposed rule, CMS discusses the status of the development and implementation for both acute and chronic episodes, including attribution rules, risk-adjustment methodology, and relevant information included in Supplemental QRURs. CMS notes that they intend to broaden the range of conditions that addressed by episode grouping, such as measures adapted from the Hospital VBP Program. CMS also discusses how to align episode measures with clinical quality measures included in PQRS and how to align episode measures across provider settings. In the FY 2015 IPPS proposed rule CMS discussed six clinical episode-based condition-specific measures for hospitals; CMS also adapted these measures for use in the 2012 Supplemental QRURs. These measures included: (1) kidney/urinary tract infection; (2) cellulitis; (3) gastrointestinal hemorrhage; (4) hip replacement, (5) knee replacement/revision; and (6) lumbar spine fusion/refusion. Further details about these measures and related issues can be found in “Detailed Methods of the 2012 Medical Group Practice Supplemental Quality and Resource Use Reports (QRURs)” at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Episode-Costs-and-Medicare-Episode-Grouper.html>. CMS is considering whether to propose their inclusion in the VM through future rulemaking.

**Approach to Setting the VM Adjustment Based on PQRS Participation**

Similar to the categorization of groups of physicians eligible for the CY 2016 VM, **CMS proposes to use a two-category approach for the CY 2017 VM based on participation in the PQRS by groups and solo practitioners** (PQRS reporting requirements are discussed in section K of this summary).

<b>Category 1</b>	<b>Category 2</b>
<p><b>INCLUDES:</b></p> <ul style="list-style-type: none"> <li>• Groups that meet the criteria for satisfactory reporting data on PQRS quality measures via the GPRO (through use of the web-interface, EHR, or registry reporting mechanism)</li> <li>• Groups that do not register to participate in the PQRS GPRO in CY 2015 and that have at least 50 percent of the group’s EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals (through the use of claims, EHR, or registry reporting mechanism) for the CY 2017 payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS-qualified clinical data registry for the CY 2017 PQRS payment adjustment.</li> <li>• Solo practitioners that meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals (through the use of claims, EHR or registry reporting mechanisms) for the CY 2017 PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS-qualified clinical data registry for the CY 2017 PQRS payment adjustment.</li> </ul>	<p><b>INCLUDES:</b></p> <p>those groups and solo practitioners that are subject to the CY 2017 VM and do not meet the criteria for Category 1. As discussed above, CMS is proposing a -4.0 percent VM to groups with two or more EPs and solo practitioners that are in Category 2.</p>

**Payment Adjustment Amount**

The ACA requires the VM to be implemented in a budget neutral manner. In the CY 2014 PFS FR, CMS adopted a policy to apply a maximum downward adjustment of 2.0 percent for the CY 2016 VM for groups of physicians with 10 or more EPs that are in Category 2 and for groups of physicians with 100 or more EPs that are in Category 1 and are classified as low quality/high cost groups. CMS received comments suggesting that the payment adjustment under the VM must be significantly to drive physician behavior toward achieving high quality and low cost and that the VM should be increased incrementally from 2.0 percent and subject to annual review. In CY 2017, CMS proposes to increase the downward adjustment under the VM by doubling the amount of payment at risk from 2.0 percent in CY 2016 to 4.0 percent in CY 2017.

Table 58, shows the proposed quality-tiering payment adjustment amounts for CY 2017 based on CY 2015 performance.

**TABLE 58: CY 2017 Value-Based Payment Modifier Amounts**

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+2.0x*	+4.0x*
Average Cost	-2.0%	+0.0%	+2.0x*
High Cost	-4.0%	-2.0%	+0.0%

\*Groups and solo practitioners eligible for an additional +1.0x if reporting Physician Quality Reporting System

As discussed above, CMS proposes to apply the VM to physicians and nonphysician EPs that participate in the Shared Savings Program beginning with the CY 2017 payment adjustment period. CMS notes they will have the final list of ACOs that will participate in the Shared Savings Program during the payment adjustment period and their participant TINs during the fall of CY 2016; this final list, however, may not be available until after the beginning of the payment adjustment period. Therefore, CMS proposes to calculate preliminary payment adjustment factors (“x” in Table 58) prior to the beginning of the payment adjustment period and subsequently finalize the payment adjustment factors after the final ACO participation list is completed. For more information on changes related to groups participating in ACOs and the MSSP, contact us at [healthpolicy@entnet.org](mailto:healthpolicy@entnet.org).

*For additional information on the VM program and the quality and cost measures, access the [CMS presentation here](#):*

**14) [Electronic Health Record Incentive Program \(EHR\) \(p. 384\)](#)**

The Electronic Health Records (EHR) Meaningful Use (MU) Incentive Program is an initiative designed to facilitate the use of certified EHR technology (CEHRT) in clinical settings. Eligible professionals, hospitals, and critical access hospitals that demonstrate meaningful use of EHRs are eligible for incentive payments. **Starting in 2015, EPs, hospitals and critical access hospitals that do not successfully demonstrate MU of EHRs will be subject to penalties.** Providers must report the required number of objectives and CQMs (and meet other reporting requirements) to be successful participants. In order for EPs to successfully report the CQMs selected by CMS, EPs must report in the form and manner specified by CMS.

Under the CY 2014 MPFS final rule, EPs seeking to report CQMs electronically under the EHR Incentive Program are required to use the most recent version of the electronic specifications for the CQMs and have CEHRT that is tested and certified to the most recent version of the electronic specifications for the CQMs. According to CMS, the latter requirement created additional difficulties and expenses, and therefore it is proposes to change the requirement. Specifically, CMS proposes in CY 2015 EPs not be required to ensure that their CEHRT products are recertified to meet the most recent version of the electronic specification for CQMs. **However, EPs must still report the most recent version of the electronic specifications for the CQMs.** In 2015, if CMS discover errors in the most recently updated electronic measure specifications for a certain measure, CMS would use the version that immediately preceded the most recent update. This is to account for instances where errors are discovered in the update electronic measure specifications.

**[Additional Information](#)**

The CY 2015 Proposed MPFS rule with comment period on interim policies is published at: <http://www.gpo.gov/fdsys/pkg/FR-2014-07-11/pdf/2014-15948.pdf>. CMS will respond to comments in the CY 2015 MPFS final rule. The electronic submissions of comment can be made at URL: [www.Regulations.gov](http://www.Regulations.gov) search for CMS and final rules.