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Analysis of the CY2015 Final Rule for Physician Fee Schedule

The table below includes a summary of the Consumer-Purchaser Alliance's most recent comments on the CY 2015 Medicare Physician Fee Schedule (PFS) proposed rule, as well as CMS's response in the PFS final rule. Noteworthy changes include applying the value-based payment modifier to all physicians and doubling the incentive (2% to 4%), the application of a financial penalty for non-participation in PQRS, the establishment of a payment for non face-to-face chronic care management services, and the first change in ACO measures in three years. We are disappointed that many low-value process measures were retained in PQRS and concerned that these measures allow some specialists to earn credit for participation without providing information of value to consumers and purchasers. At the same time, we applaud CMS for implementing a new requirement to report from a cross-cutting measure set that applies to all physicians who see patients in face-to-face encounters.

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POTENTIALLY MISVALUED SERVICES	CMS has contracted with two outside entities to develop validation models for relative value units (RVUs) RAND and Urban Institute. Did not solicit comments on these projects and made no proposals.	Encouraged CMS to explore recommendations by Urban Institute and RAND on how to overcome challenges in collecting objective time data. Anticipate new objective time measures from participating sites and reports.	Acknowledged the receipt of comments on these projects. Future changes to payment policies will be issued in a proposed rule and subjected to public comment.
Off-Campus Hospital Departments	Begin collecting data on services furnished in off-campus provider-based departments beginning in 2015.	Supported the proposal to collect data.	Finalized requirement for hospitals report a modifier, and for physicians and other practitioners to use a new site of service code on professional claims in 2016. Hospital reporting will be voluntary for 2015 and mandatory in 2016.

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		Recommend CMS reconsider a proposal to reduce payments when a Medicare physician office payment exceeds the amount paid in the outpatient hospital department or ambulatory surgical center (ASC) setting.	Acknowledged comments but did not propose, and, is not finalizing any adjustment to payments furnished in the off-campus setting.
Medicare Telehealth Services	CMS proposed to add 4 services to the list of services that Medicare beneficiaries can receive via telehealth for CY2015: • Annual wellness visits; • Psychoanalysis; • Psychotherapy; and • Prolonged evaluation and • Care/Care Coordination	Supported adding four new services to the list of Medicare telehealth services.	Finalized proposal.
Valuing New, Revised and Potentially Misvalued Codes	Revisions to misvalued codes and changes to payment rates for particular services (excluding entirely new services never before valued) to go through notice and comment rule-making before being adopted.	Supportive of the new policy; commend CMS's efforts to increase transparency.	Finalized proposal.

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Complex Chronic Care Management	Proposed a per-patient payment of $41.92 that can be billed no more than once per month for patients with two or more chronic conditions.	Supported efforts to improve care coordination by promoting complex care management (CCM); do not believe this can be achieved solely with the creation of a new payment code for non face-to-face chronic care management.	Beginning January 1, 2015, will make a per-beneficiary-per-month payment at a rate of **$40.39** for CCM services provided to patients with two or more significant chronic conditions. (* payment amount reduced due to a mandated adjustment to the conversion factor)
	Eliminate the requirement that CCM services (as well as transitional care management services) be furnished under direct physician supervision.	Supported proposal.	Finalized proposal.
	Use of electronic health records (EHRs) or other health information exchange platform accessible to all providers in the practice and transmissible electronically to care team members outside of the practice.	Supported proposal.	Finalized requirement for the version of the certified EHR that is in use on December 31 of the prior calendar year for the EHR Incentive Programs to bill for CCM services.

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		Urged CMS to: - Continue its commitment to improve payment care management services - Strengthen standards in the area of quality measures and patient engagement - Create operational definitions for activities that it lists in the scope of complex chronic care management services	Noted that payment for CCM is only one part of a multi-faceted CMS initiative to improve Medicare beneficiaries' access to primary care. Models being tested through the Innovation Center will continue to explore other primary care innovations.
PHYSICIAN COMPARE	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.	Support for the expansion of public reporting.	Finalized proposal.
	Publicly report 20 PQRS individual measures reported in 2013 and collected through a registry, EHR, or claims in 2015.	Support reporting of more individual measures.	Did not finalize proposal to publicly report 20 PQRS individual-level measures reported in 2013 due to concerns that these data were submitted to CMS without the

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			understanding that they would be made public.
	Report Million Hearts on Physician Compare.	Support for reporting on Million Hearts.	Modified proposal: EPs will receive a green check mark indicating support for Million Hearts if they satisfactorily reports all four individual measures: 1) Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic; 2) Preventive Care and Screening: Tobacco Use; 3) Controlling High Blood Pressure; and 4) Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
	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.	Support public reporting of CAHPS survey data on PC.	Finalized proposal.

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	Composites: Sought comments on also creating *composites* using 2015 data and publishing composite scores in 2016 by grouping measures based on the PQRS GPRO measure groups.	We strongly support the creation of composite scores and believe that these scores will provide consumers who access Physician Compare with a more concise, and understandable picture of physician quality.	Not finalizing any decisions regarding composite scores at this time: concept was put forth merely to seek comment and no formal proposal was made.
	Benchmarks: Publicly report on Physician Compare benchmarks in 2016 for 2015 PQRS GPRO data (based on 2014 data) level PQRS measures (date not specified).	Please see MSSP/ACO comments below.	Did not finalize and will engage stakeholders in discussions of potential benchmarking methodologies to propose in future rules.
	Include specialty society measures on the site and linking Physician Compare to specialty society websites that publish non-PQRS measures.	Did not support.	CMS sought comment but did not make a formal proposal; no change was finalized.
PHYSICIAN QUALITY REPORTING SYSTEM (PQRS)	Eligible Professionals (EPs) who do not satisfy 2015 PQRS reporting requirements or participate in a Qualified Clinical Data Registry (QCDR) are subject to the 2017 PQRS payment penalty of 2%.	Supported proposal.	Finalized proposal.

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PQRS Quality Measures	Proposed to remove 73 measures from PQRS for 2015. CMS offered rationale for removing each of these measures, such as performance near 100% (i.e., topped out measures), low-value process that does not meaningfully contribute to improved outcomes, and lack of measure steward to maintain measures going forward. Please review Table 24 in the proposed rule for the complete list of measures proposed for removal.	Supported removal of process measures that do not meaningfully contribute to improved patient outcomes and the removal of measures where the performance rates are close to 100%, suggesting no gap in care.	Removed 50 measures from the program. CMS offered various rationale for retaining the measures that were proposed for removal but remain in the program after the final rule, such as identification of a measure steward to maintain a measure, continued ability of a specialty or group of clinicians to participate in PQRS, and importance to measure clinical concepts at multiple levels (e.g., facility level and individual clinician level). See Table 55 of the final rule for the responses and final decisions related to the measures removed from reporting under PQRS.
New PQRS Measures Available for Reporting for 2015 and Beyond	Proposed to add 28 new individual measures to fill existing measure gaps. See Table 22 in the proposed rule for specific measures proposed and rationale for each measure.	Our support, or conditional support, for the inclusion of the 28 new measures in PQRS is based on the recommendations of the Measures Application Partnership (MAP) as reflected in. MAP Pre-Rulemaking Report: 2014 Recommendations on Measures for More than 20 Federal Programs; January 2014.	Added 20 new individual measures to be available for claims-based reporting, bringing the PQRS individual measure set to 255 measures. The proposed measures that were not finalized were excluded for a variety of reasons such as inappropriateness for claims reporting, redundancy with other measures in the program, and ongoing measure testing and evidence development. Please review Table

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			53 for specific measures finalized and excluded, along with CMS's rationale.
Cross-cutting measures	Proposed requirement to report at least two cross-cutting measures from a measure set (see Table 21 for list of proposed cross-cutting measures). Measures proposed to be available for reporting by claims, registry, or EHR.	Supported proposal.	Finalized proposal and proposed cross-cutting measures and added an additional cross-cutting measure of poor diabetes control to the set. Please review Table 52 in the final rule for the specific measures included.
PQRS Measures Groups	Increase the number of measures that may be included in a measures group from a minimum of four measures to a minimum of six.	Supported proposal.	Finalized proposal to increase measure groups from a minimum of four measures to a minimum of six measures, removed four measure groups and added two measure groups. See Tables 57-79 in the final rule for the final measure groups and rationale for changes.
Measures Available for Reporting in the GPRO Web Interface	Proposed a number of measure additions and removals for measure groups reported through the GPRO web interface, available in Tables 26-48 of the proposed rule.	Supported proposed adoption of Depression Remission at Twelve Months (NQF #0710) in the 2015 GPRO Web Interface reporting option for ACOs and group practices (see MSSP/ACO comments below).	CMS finalized adoption of Depression Remission at Twelve Months in the 2015 GPRO web interface reporting option for PQRS and MSSP. For other specific proposals, please review Table 79 for measures removed and Table 80 for measures added.

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Reporting Mechanisms	Sought comment on whether (in future rulemaking) to propose to allow more frequent submissions of data, such as quarterly or year-round submissions, rather than annually.	Supported proposal.	Will consider the commenters' feedback if and when this policy is proposed in future rulemaking.
Qualified Clinical Data Registries (QCDRs)	Proposed to make available on Physician Compare, 2015 Qualified Clinical Data Registry (QCDR) measure data collected at the individual level or aggregated higher level of the QCDR's choosing – such as the group practice level, if technically feasible.	Support measure data collected at the individual level.	Finalized proposal to publicly report individual EP-level QCDR measures with some modifications, including not publishing first year measures.
	Publicly report individual EP-level QCDR measures: 2015 QCDR data will be publicly reported in 2016 on the Physician Compare website, and require these data to also be publicly reported on the QCDR websites.	Support publicly reporting individual EP-level QCDR measures.	Finalized proposal to publicly report individual EP-level QCDR measures with some modifications, including not publishing first year measures. Did not finalize proposal to require these data to also be publicly reported on the QCDR websites.

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	Extending the deadline for the QCDR's submission of quality measures data QCDRs have one month to post quality measures data after this deadline.	Did not comment.	
	Data must be available on a continuous basis and be continuously updated as the measures undergo changes in measure title and description, as well as when new performance results are calculated.	Supported the proposal.	Finalized proposal.
	15 days following CMS approval of measure specifications, the QCDR must publicly post the measures specifications.	Supported requirement for transparency of measure specification	Finalized proposal.
	To avoid the downward 2017 PQRS payment adjustment by participating in a QCDR, eligible professionals (EPs) must: - report each measure for at least 50% of the EPs patients; - report on at least 3 outcome measures	Supported the proposal.	Finalized proposal.

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	Change the limit on the number of non-PQRS measures that a QCDR may submit on behalf of an EP from 20 measures to 30 (beginning with 2017 PQRS adjustment).	Did not comment.	Finalized proposal.
Consumer Assessment of Healthcare Providers Surgical Care Survey (S-CAHPS)	Recognized the importance of the S-CAHPS and wants to allow for reporting of S-CAHPS in the PQRS. Did not feel it is technically feasible at this time due to the cost and time it would take to find vendors to collect S-CAHPS data.	Supported introduction of S-CAHPS in the PQRS measure set.	Restated that it is not technically feasible due to cost and time. Taking comments into consideration as we continue to work to introduce S-CAHPS in the PQRS measure set for future year.
ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM	Beginning in CY 2015, EPs would not be required to ensure that their CEHRT products are recertified to the most recent version of the electronic specifications for the CQMs.	Did not support proposal.	Finalized proposal.
	Requiring EPs to report on the most recent version of the electronic specifications for the CQM.	Did not support proposal.	Finalized proposal.

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	Relaxing requirements pertaining to the group reporting option for the Comprehensive Primary Care (CPC) initiative to cover three domains under the National Quality Strategy (NQS).	Did not support proposal.	Finalized proposal.
	Beginning in CY 2015, EPs would not be required to ensure that their CEHRT products are recertified to the most recent version of the electronic specifications for the CQMs.	Did not support proposal.	Finalized proposal.
		Opposed extension of hardship exception. application deadline when submission period was reopened in Oct 2014	Interim Final Rule included in PFS making changes to regulatory language on hardship exceptions.
SHARED SAVINGS PROGRAM (MSSP/ACO)	CMS proposed to assess quality with 37 measures, rather than the current 33, beginning with the 2015 reporting period. This included adding twelve new measures and retiring eight existing measures. Specific measures proposed for 2015 are listed in Table 50 of the proposed rule.	Strongly supported inclusion of outcome, patient-reported outcome and patient experience measures (e.g., Stewardship of Patient Resources, Skilled Nursing Facility 30-Day All-Cause Readmission, All-Cause Unplanned Admissions for select conditions, and Depression Remission at Twelve Months).	Finalized 33 measures, which includes reducing number of measures reported through GPRO. New measures include outcome and patient experience measures as well as documentation of medications. The list of finalized measures is available in Table 81 of the final rule. Retired and replaced measures are listed in Table 83.

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	Four domains with equal weighting (25% each) will be maintained: Patient/Caregiver Experience; Care Coordination/Patient Safety; Preventive Health; At-Risk Populations.	Did not support including Documentation of Current Medications in the Medical Record or removing Blood Pressure <140/90.	Removed Blood Pressure <140/90 and other measures from MNCM Optimal Diabetes composite. Only included one coronary artery disease measure (CAD) so there will not be a CAD composite.
	Clarified for second or subsequent three year agreement periods (between CMS and ACO), the first year will not be pay-for-reporting for measures that were pay-for-performance in the prior agreement.	Supported proposal that pay-for-performance measures remain as P4P in subsequent three-year agreements.	Pay-for-performance measures will remain as P4P in subsequent three-year agreements.
	Adjusting the quality performance benchmarks for "topped out" measures to accommodate the belief that it may be harder for larger organizations to perform as well on these measures than smaller organizations.	Did not support the use of topped out measures.	Topped out measures can remain in the program and will use a flat percentage when results in the 90th percentile are greater than or equal to 95%.
	Additional payment rewards for quality improvement.	Support the proposal to reward ACOs that improve scores on individual measures from year to year as that is a more effective mechanism for rewarding improvement.	For each domain, an additional 4 points can be earned based on improvement. The total points that can be earned for the domain remain the same.

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VALUE-BASED PAYMENT MODIFIER (VM)	For CY 2017 apply the value modifier (VM) to physicians in groups of two or more EPs and to physicians who are solo practitioners.	Supported the proposal.	Finalized proposal.
	Increase the automatic VM downward adjustment from -2.0% (CY 2016) to -4.0% for the CY 2017 for solo practitioners who do not satisfactorily report under PQRS (through GPRO interface, EHR or registry).	Supportive of CMS proposed changes to the direction of the VM, but believe that a 4.0 percent adjustment is not sufficient to incentivize physicians to improve quality.	CMS finalized increasing the penalty from 2% to 4% in CY 2017 only for groups with 10 or more eligible professionals.
	For those practitioners who do satisfactorily report under PQRS:	Concerned that quality-tiering will exempt smaller group practices from downward payment adjustments, most of the VM penalties could fall on the shoulders of primary care physicians, who tend to practice in larger group.	
	- Increase the maximum downward adjustment under the quality tiering methodology to -4.0% for groups and solo practitioners classified as low quality/high cost.	We believe that a 4.0 percent adjustment is not sufficient to incentivize physicians to improve quality.	Finalized proposal.

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	- Upward adjustment of +4.0 for low cost/high quality providers). Groups with 10+ EPs can receive upward, neutral, or downward VM adjustment.	Recommend that payment adjustments apply to all groups, regardless of size.	Finalized increasing the penalty from 2% to 4% in CY 2017 only for groups with 10 or more eligible professionals.
Physician Feedback Program/QRURs	In late summer 2014, CMS will make individualized Quality and Resource Use Reports (QRURs) for all solo practitioners and group practices based on 2013 data.	Support providing individual level physician level feedback so that doctors know how they are performing compared to their peers within group practice.	QRURs available on CMS portal.
Payment of Secondary Interpretation of Images	Requested data on circumstances where it is appropriate to allow routine Medicare payment for a second professional component for radiology services, or whether this policy change would reduce incidences of duplicative advanced imaging studies.	Do not have the data. Believe it is not necessarily uncertainty associated with payment for secondary interpretations that inhibits physicians from using existing studies but rather access to the same EHR.	Any changes to current policy on allowing physicians to more routinely bill for secondary interpretations of images will be addressed in future rulemaking.

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Reports of Payments or Other Transfers of Value to Covered Recipients **"Open Payments program"**	CMS proposed to remove the CME exemption for reporting of payments to healthcare providers who serve as speakers for accredited continuing education programs, (see §403.904(g))	Supported proposal.	Finalizing 4 changes: 1) Deleting the definition of "covered device 2) Deleting the Continuing Education Exclusion in its entirety 3) Requiring reporting of marketed name and therapeutic areas 4) Requiring applicable manufacturers to report stocks, stock options
Methodological Refinements to Address NQF Issues Regarding the Total per Capita Cost Measure	Modifications to two--step attribution methodology to allow for consideration of primary care services furnished by non--physicians during the first phase.	Supported these changes.	Finalized proposal.
	Reverse the current exclusion of beneficiaries who are newly enrolled to Medicare during the performance period and enrolled in both Part A and Part B to capture end-of-life costs.	Supported these changes.	Finalized proposal.