The Centers for Medicare & Medicaid Services (CMS) published the final 2015 Medicare physician fee schedule (PFS) on Oct. 31, 2014. The regulation finalized policies that affect Part B payments for physician services furnished on or after Jan. 1, 2015. MGMA created this analysis exclusively for members to help them understand the new and updated policies in place for the Medicare program next year.

Medicare physician payment

Unless Congress intervenes, current law requires physician fee schedule rates to be reduced by an average of 21.2% on April 1, 2015 due to the sustainable growth rate (SGR) formula. The final rule sets the physician and anesthesia fee schedule conversion factors (CFs) for calendar year (CY) 2015. The CY 2015 PFS CF for Jan. 1, 2015 through March 31, 2015 is $35.8013. The CY 2015 PFS CF for April 1, 2015 through Dec. 31, 2015 is $28.2239. The CY 2015 national average anesthesia CF for Jan. 1, 2015 through March 31, 2015 is $22.5550. The CY 2015 national average anesthesia CF for April 1, 2015 through Dec. 31, 2015 is $17.7913. MGMA, along with the rest of the medical community, continues to work with congressional leaders, urging them to permanently fix the broken Medicare physician payment system, and replace it with a stable, predictable method that accounts for the actual cost of caring for Medicare beneficiaries.

Malpractice (MP) RVUs

CMS finalized its third comprehensive five-year review and update of Medicare malpractice (MP) RVUs. The MP RVUs were calculated based on updated MP premium data obtained from state insurance rate filings. The methodology largely parallels the process used in the 2010 update, with MP premium data coming primarily from state departments of insurance. MP RVUs comprise a much smaller portion (4.3%) of Medicare payment in comparison to work or practice expense RVUs, which account for 50.9% and 44.8% of Medicare payments, respectively. CMS estimates the MP RVUs changes will result in an overall 1% payment increase for three specialties and an overall 1-2% decrease for seven specialties. For all other specialties, CMS estimates the overall payment impact to be less than 1% (Table 93).

CMS finalized MP RVU updates as proposed with minor modifications. Gynecological oncology is now crosswalked to the risk factor for general surgery instead of obstetrics gynecology. In determining the risk factor for low volume services, CMS overrides the dominant specialty from claims data with the recommended specialty for the low volume service codes. For all other low volume services, CMS uses the risk factor of the dominant specialty from Medicare claims data. Due to lack of sufficient data, the agency postponed review of anesthesiology MP RVUs until 2016.
Medicare telehealth services

CMS adds the following services to the 2015 list of approved telehealth services:

- Annual wellness visit HCPCS codes G0438 and G0439 (to view criteria, download MGMA’s analysis of the 2011 Medicare physician fee schedule)
- Psychotherapy services CPT codes 90845, 90846 and 90847
- Prolonged service office CPT codes 99354 and 99355

The Medicare telehealth originating site facility fee is statutorily increased from $24.63 to $24.83 in 2015 (Table 13). Moving forward, the agency will provide a list of Medicare telehealth codes and descriptors on the CMS website.

Misvalued codes

CMS continues its ongoing efforts to evaluate and modify potentially misvalued codes. Below is a summary of three key areas in the rule that have the broadest impact on Medicare providers.

Eliminating 10- and 90-day global surgery codes

CMS finalized its proposal to transition and revalue all 10- and 90-day global surgery services with 0-day global periods, beginning with the 10-day global services in 2017 and following with the 90-day global services in 2018. The agency cited concerns regarding potential inaccuracies with the current information used to price these services, including whether current global surgical values accurately represent the number of post-operative visits furnished to beneficiaries. Newly-valued 0-day global surgical codes will replace 10- and 90-day global surgical codes. Physicians will bill separately for services such as follow-up office visits.

CMS states it intends to consider feedback as it implements the rule and engage affected stakeholders for input on appropriate valuation and coding for surgical services during this significant transition. As part of this process, CMS plans to collect data regarding the number of visits typically furnished during post-operative periods and provide further details during the 2016 Medicare physician fee schedule rulemaking process. Additionally, the agency will assess whether another construction of a bundled payment for surgical services could be used in the future.

Review high expenditure services across specialties with Medicare allowed charges of $10 million or more

CMS proposed 68 codes (Table 11) as potentially misvalued based on the fact that they account for a large portion of Medicare expenditures and have not been reviewed since 2009. Due to the significant impact these codes have on PFS payments at the specialty level, the agency proposed reviewing the relativity of the codes to ensure work and direct practice expense (PE) PE RVUs are appropriately valued relative to other codes within and across specialties. While the agency signals intent to review codes...
accounting for high expenditures in the future, CMS did not finalize plans to review these codes at this time. The agency put this review on hold as it focuses on the considerable effort necessary to transition from 10- and 90-day global surgical codes to 0-day codes.

Evaluate services that include moderate sedation as an inherent part of furnishing the procedure

CMS originally proposed evaluating more than 300 diagnostic and therapeutic procedures in Appendix G of the American Medical Association's (AMA's) CPT Manual, the codes for which moderate sedation was determined an inherent part of furnishing the procedure and that consequentially, only the single procedure code is appropriate. The agency intended to weigh how to value these codes to ensure accurate payment for moderate sedation when furnished, while avoiding potential duplicative payments when anesthesia is furnished and billed separately. Ultimately CMS decided not to evaluate the codes at this time. It intends to address this topic in future notice and comment rulemaking, taking into account the comments received on the proposed 2015 Medicare physician fee schedule.

Process for reviewing misvalued codes

CMS is required by statute to review potentially misvalued codes and make appropriate adjustments to the relative values of these services. The agency finalized a modified process for reviewing new, revised and potentially misvalued services, acknowledging a number of challenges related to the existing process, including the timing of rulemaking by CMS, the AMA CPT Editorial Panel and the AMA/Specialty Society Relative (Value) Update Committee (RUC). The modified process aims to strike a balance between CMS' proposal and comments received, including those outlined in a comment letter from MGMA, the AMA and 71 other specialty societies.

CMS modified its proposal to consider values for all new, revised and potentially misvalued codes for which it has complete RUC recommendations by Jan. 15 of the preceding year by pushing back the RUC recommendation deadline to Feb. 10. While the agency initially proposed a new process with the PFS proposed rule for 2016, it delayed this change for one year and will instead use 2016 as a transition year. Beginning with rulemaking for 2017, under the new process CMS will propose values for the majority of new, revised, and potentially misvalued codes and consider public comments before establishing final values for the codes. It will use G-codes as necessary to facilitate continued payment for certain services for which the agency does not receive RUC recommendations in time to propose values. However, the agency stated its aim to minimize the use of G-codes, which, as MGMA argued in a comment letter, cause unnecessary complexity and administrative burdens. CMS will adopt interim final values in the case of wholly new services for which there are no predecessor codes or values, and for which it does not receive RUC recommendations in time to propose values.

Collecting hospital outpatient department information

CMS stated it would like to better understand the trend of hospital acquisition of physician offices and subsequent treatment of those locations as off-campus provider-based outpatient departments, which affects payments under the PFS and Medicare beneficiary cost-sharing. Therefore, the agency will collect
information on the type and frequency of outpatient hospital services and physician services furnished in off-campus provider-based departments of a hospital.

For physicians, CMS did not finalize its proposed healthcare common procedure coding system (HCPCS) modifier, opposed by MGMA. Instead, the agency will establish two new place of service (POS) codes that physicians will be required to report on professional claims. This includes one POS code to identify outpatient services furnished in an on-campus, remote or satellite location of a hospital, and one code to identify services furnished in an off-campus provider-based department of a hospital. Physicians are required to report the new POS codes as soon as they become available. The agency stated it does not anticipate new POS codes will be ready and integrated into CMS physician claims systems before July 1, 2015, and promised to give proper notice prior to implementation.

For hospital claims, CMS created a new HCPCS modifier that hospitals are required to report with every code for outpatient hospital services furnished in an off-campus provider-based department of a hospital. CMS will add this 2-digit modifier to the HCPCS annual file as of Jan. 1, 2015, with the label “PO,” the short descriptor “serv/proc off-campus pbd” and the long descriptor “services, procedures and/or surgeries furnished at off-campus provider-based outpatient departments.” Reporting this modifier is voluntary in 2015, but mandatory beginning in 2016. This modifier is not required for remote locations of a hospital, satellite facilities or for services furnished in an emergency department.

Establishing RVUs for CY 2015

As part of the 2014 final Medicare PFS, CMS established interim final values for a number of codes. In the final 2015 Medicare PFS, the agency responded to comments on the interim final values and either finalized them or made modifications. Of the approximately 250 codes with 2014 interim final values, CMS finalized values for all but 33 codes. Most of the code revisions are small, but a few are more substantial. The codes and finalized or revised values can be viewed in Table 15. The agency also established revised RVUs for another group of almost 250 codes, effective on an interim final basis Jan. 1, 2015. These are codes CMS previously indicated it would evaluate as potentially misvalued and are spread across many specialties. CMS may make further refinements in the 2016 Medicare PFS to these codes, listed in Table 25.

As a result of CPT code set changes for 2015, including the deletion of certain CPT 2014 codes, CMS introduced approximately 30 G-codes for a group of lower gastrointestinal endoscopy (Table 26) and radiation therapy services (Table 27). The agency created these G-codes to allow practitioners to continue reporting these services in the same way in 2015 as in 2014. Payment under the PFS for the new G-codes will be based on the same inputs used to calculate the 2014 CPT codes they are replacing, and all payment policies applicable to the 2014 CPT codes will apply to the replacement G-codes. The new and revised 2015 CPT codes will no longer be recognized by Medicare; practices must bill Medicare for these services using the new CMS-created G-codes.

Practices can view 2015 Medicare codes, RVUs and other payment information for all 2015 payable codes in Addendum B. RVUs and other payment information for all codes subject to public comment are
available in Addendum C. The time values for all 2015 codes are listed in a download file titled “CY 2015 PFS Physician Time.” All three are available on the CMS website and can be found under downloads for the 2015 PFS final rule.

Chronic care management services

In 2014, CMS finalized a new Medicare service, Chronic Care Management (CCM), with plans to set payment for and implement use of the code beginning in 2015. The specific elements finalized in 2014 can be viewed in MGMA’s 2014 Final Medicare Physician Fee Schedule Analysis. The agency finalized CCM provisions for 2015 in the most recent PFS, making a few changes to the 2014 rules, establishing additional requirements and setting payment for the service.

While CMS originally planned to use a Medicare-specific G-code, it instead finalized use of a CPT code (99490). CCM can be furnished to patients with two or more chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. In order to bill for this non face-to-face service, at least 20 minutes of services must be furnished per calendar month. CMS set an average payment rate of $42.60 for CCM, which can be billed up to once per month per qualified patient, and established the following RVUs:

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
<th>Description</th>
<th>Physician Work RVUs</th>
<th>Non-Facility PE RVUs</th>
<th>Facility PE RVUs</th>
<th>Mal-Practice RVUs</th>
<th>Total Non-Facility RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>99490</td>
<td>Chronic care management</td>
<td>0.61</td>
<td>0.54</td>
<td>NA</td>
<td>0.04</td>
<td>1.19</td>
</tr>
</tbody>
</table>

The agency finalized changes regarding incident to billing for CCM that modify what was previously finalized in the 2014 Medicare PFS. Specifically, services provided by clinical staff under general (rather than direct) supervision are now eligible to be counted for purposes of incident to billing of the CCM service. Additionally, rather than limiting the use of general supervision under incident to billing outside of regular business hours, CMS will allow the use of general supervision during business hours. The agency also finalized its proposal to permit the non-face-to-face portion of the Medicare transitional care management services provided by clinical staff incident to the services of a practitioner to be furnished under the general supervision of a physician or other practitioner.

In the proposed rule, CMS introduced a new scope of service requirement for the use of certified EHR technology (CEHRT), which would have to be certified to at least 2014 Edition certification criteria and need to include an electronic care plan. Based on comments from MGMA and others expressing concerns
about the 2014 Edition certification criteria, CMS modified this requirement. The revised requirement
maintains that CCM services must be furnished using, at a minimum, the edition(s) of certification criteria
acceptable for the EHR Incentive Programs as of Dec. 31st of the calendar year preceding each PFS
payment year in order to meet the final core technology capabilities (structured recording of
demographics, problems, medications, medication allergies and the creation of a structured clinical
summary). Practitioners must also use this technology to fulfill the CCM scope of service requirements
whenever the requirements reference a health or medical record. For 2015 CCM services, practitioners
can use EHR technology certified to either the 2011 or 2014 edition(s) of certification criteria.

CMS finalized requirements regarding electronic care plans. Practices must electronically capture care
plan information and make it available on a 24/7 basis to a practice’s clinicians furnishing CCM services
(i.e., those whose time is counted towards the practice billing for the CCM code). Practices may satisfy
the 24/7 care plan access requirement in a number of ways, including remote access to an EHR, web-
based access to a care management application, or web-based access to a health information exchange
service that captures and maintains care plan information. Billing practitioners must be able to share care
plan information electronically (other than by facsimile) as appropriate with other practitioners furnishing
care to the beneficiary. CMS did not mandate the use of a specific electronic solution to furnish the care
plan element of the CCM service, only that the method must be electronic and cannot include facsimile
transmission.

Table 33 provides an overview of the final CCM scope of service elements and billing requirements for
2015. We expect CMS to issue further educational materials on this new service and will share them with
members via the Washington Connection as they become available.

**Definition of colorectal cancer screening tests**

Citing recent studies that suggest an increase in the percentage of colonoscopies and upper endoscopy
procedures furnished using an anesthesia professional, as well as an analysis of 2013 Medicare claims
data, CMS concluded that the prevailing standard of care for colonoscopies is undergoing a transition and
that anesthesia separately provided by an anesthesia professional is becoming the prevalent practice.
Therefore, the agency revised the definition of “colorectal cancer screening tests” to include anesthesia
that is separately furnished in conjunction with screening colonoscopies, effective Jan. 1, 2015.

Colorectal cancer screening tests are preventative services for which both coinsurance and deductibles are
waived under section 4104 of the Patient Protection and Affordable Care Act (ACA). By including related
anesthesia within the definition of colorectal cancer screening tests, Medicare beneficiaries will be
relieved of cost-sharing obligations for such services.

CMS noted that it will establish a modifier for billing the relevant anesthesia codes and provide
“appropriate and timely information” to facilitate correct billing of these services.
Open Payments Program

CMS finalized its proposal to eliminate the Open Payments Program exemption for reporting payments or transfers of value provided as compensation for speaking at continuing medical education programs. These payments must now be reported unless the situation qualifies for another reporting exclusion. Manufacturers reporting compensation paid to physician speakers may opt to distinguish if the payment was provided at an accredited or certified continuing education program versus an unaccredited or non-certified continuing education program by selecting the appropriate nature of payment category. No changes were made to a related exclusion, under which CMS does not require reporting for indirect payments or other transfers of value where the applicable manufacturer/group purchasing option (GPO) is unaware of the identity of the covered recipient during the reporting year or by the end of the second quarter of the following reporting year.

CMS finalized its proposal to make stock, stock options and any other ownership interests distinct reporting categories, rather than one combined category. Reporting of marketed names for non-covered drugs, devices, biologicals or medical supplies continues to be optional. Based on stakeholder feedback, CMS continues to allow an option to report a device or medical supply marketed name, therapeutic area or product category when reporting research payments. Although CMS initially proposed these policies would become effective in 2015, the agency finalized a 2016 effective date to allow more time for implementation.

Physician Compare

CMS increased the amount of information it plans to display on the Medicare Physician Compare website, which contains details about individual physicians and group practices. Table 48 contains a list of website additions made in recent years, several of which go into effect in 2015.

CMS finalized its proposal to make 2015 PQRS group practice reporting option (GPRO) performance across group reporting mechanisms – GPRO web interface, registry and EHR – available for public reporting on Physician Compare in 2016. Additionally, all measures reported by Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) in 2015 will be available for reporting on Physician Compare in 2016. Reported measures must meet a minimum sample size of 20 patients. However, not all measures will be reported; CMS stated in the final rule that it will conduct consumer testing and may limit measures displayed on Physician Compare to those that are most beneficial and easily understood by beneficiaries.

In 2016, Physician Compare will also reflect 2015 patient experience data for all group practices of two or more eligible professionals (EPs) that meet the specified sample size requirements and collect data via a CMS-certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) vendor. Patient experience data available for reporting includes 12 summary survey CAHPS for PQRS measures and CAHPS for ACO measures.
CMS signaled its intent to proceed with plans to add more data on individual physicians. The agency will consider including on Physician Compare all 2015 individual EP PQRS measures collected through claims, registry, qualified clinical data registry and EHR-based reporting, with the exception of those measures new to PQRS in 2015. After outreach and consumer testing, the agency will decide specifically which individual PQRS measures to report on the website.

CMS decided not to group performance measures into broader quality composite scores or add benchmarks to Physician Compare, which would show how a group or individual performed relative to their peers. The agency stated it will reconsider both ideas in future rulemaking.

A summary of the data finalized for public reporting on Physician Compare can be found in Table 49.

**Physician Quality Reporting System (PQRS)**

2014 was the last year to earn an incentive under PQRS. CMS will now apply a 2% Medicare payment reduction in 2017 to EPs and group practices who do not successfully report data on PQRS quality measures in 2015. The agency finalized five total individual options and nine group practice reporting options for reporting to avoid the 2017 PQRS payment adjustment.

*Options for satisfactorily reporting 2015 PQRS quality data to avoid a 2017 penalty: Individual EPs*

**Claims and Qualified Registry:** EPs must report at least nine measures covering at least three of the National Quality Strategy (NQS) domains and report each measure for at least 50% of the EP’s Medicare Part B fee-for-service (FFS) beneficiaries seen during the reporting period to which the measure applies.

**Direct EHR or EHR Data Submission Vendor:** EPs must report at least nine measures covering three NQS domains. If an EP is unable to report on nine measures through CEHRT, they must report on all measures that include Medicare patient data in order to avoid the 2017 PQRS penalty. EPs are required to report Medicare patient data on at least one measure.

**Qualified Clinical Data Registry (QCDR):** EPs must report nine measures covering three NQS domains for at least 50% of an EP’s total patient population seen during the reporting period, including at least two outcomes measures as part of the required nine. If two are not available, EPs must report at least one outcome measure in addition to one of the following types of measures: resource use, patient experience of care, efficiency/appropriate use or patient safety. While CMS did not include “patient safety” as one of the additional types of measures for reporting in the 2015 proposed fee schedule, the agency added this category to provide EPs who do not meet the nine-measure threshold another option to successfully report.

**Measures Groups via a Qualified Registry:** Individual EPs reporting on measures groups via a qualified registry must report at least one measures group over the 12-month reporting period. Each measures group must include at least 20 patients, the majority of which (11 patients) must be Medicare Part B FFS patients. Measures groups containing a measure with a 0% performance rate will not count.
Cross-cutting measures

For individual EPs reporting via claims or a qualified registry and group practices reporting via a qualified registry, if the EP sees at least one Medicare patient in a face-to-face encounter, the EP or group practice must report at least one cross-cutting measure (Table 52). This cross-cutting measure would apply toward the nine PQRS measures across three NQS domains required for successful reporting.

CMS will determine if an EP has had a face-to-face encounter based on whether the EP bills Medicare for associated services such as general office visits, outpatient visits and surgical procedures. Telehealth visits are not considered face-to-face encounters.

Options for satisfactorily reporting 2015 PQRS quality data for to avoid a 2017 penalty: Groups with 2-99 EPs

Starting in 2015, CMS modified the deadline for groups to register to participate in PQRS GPRO from Sept. 30 to June 30 of the reporting year. In order to register under GPRO using the Physician Value (PV)-PQRS registration system, the group practice must have an approved Individuals Authorized Access to the CMS Computer Services (IACS) account and indicate its selected reporting method for the 12-month period.

GPRO-Web Interface (groups with 25 or more EPs only): A group practice must report data on all measures for the first 248 consecutively-assigned patients. If the pool of assigned beneficiaries is less than 248, the group must report on 100% of its eligible patients. Groups are required to report on at least one measure for which there is Medicare patient data.

GPRO-Registry and EHR Reporting: A group practice reporting via a registry must report at least nine measures covering three NQS domains for at least 50% of its Medicare Part B FFS beneficiaries seen during the reporting period to which the measure applies. If fewer than nine measures covering three NQS domains apply to the group, it must report on 50% of the group’s Medicare Part B FFS beneficiaries for each measure, up to eight measures covering between one and three NQS domains.

A group reporting via an EHR must report nine measures covering at least three NQS domains, or should fewer than nine measures apply, the group must report all measures to which patient data applies, with a minimum of one measure. All groups must report on at least one measure for which there is Medicare patient data.

Criteria for satisfactorily reporting PQRS quality data for avoiding a 2017 penalty: Groups of 100+ EPs

Beginning in 2015, CMS will no longer pay to administer the CAHPS for PQRS survey via a CMS-certified survey vendor. Groups with 2-99 EPs registered to participate in PQRS GPRO have the option to report via the CAHPS for PQRS survey. Groups of 100 or more EPs registered to participate in GPRO are required to meet one of the following three options in order to satisfactorily report. These reporting options are also available to group practices with two or more EPs registered to participate in GPRO.
**Option 1- Registry:** Groups of two or more EPs must report all CAHPS measures via a CMS-certified survey vendor in addition to six measures outside of CAHPS covering two NQS domains. Should fewer than six measures apply, the group must report up to five measures. Of these additional measures, if any EP has seen at least one Medicare patient face-to-face, the group practice must then report at least one cross-cutting measure. Groups with fewer than six applicable measures can still satisfactorily report via a registry if the group reports on all measures applicable to the group’s practice, including those in the cross-cutting measure set.

**Option 2- EHR:** Groups of two or more EPs must report all CAHPS survey measures via a CMS-certified survey vendor, in addition to six measures outside of CAHPS covering two NQS domains using a direct CEHRT product or EHR data submission vendor that uses CEHRT. One of these measures must include Medicare patient data. Should fewer than six measures apply to the group, the group must report all applicable measures.

**Option 3- GPRO-Web Interface:** Groups of 25-99 EPs must report all CAHPS survey measures via a CMS-certified survey vendor in addition to reporting all measures included in the GPRO-web interface, populating data for the first 248 consecutively-ranked and assigned beneficiaries in the group’s sample for each module or measure. Should the patient pool contain fewer than 248 patients, the group must report on 100% of its assigned beneficiaries and include at least one measure for which Medicare patient data exists.

**Measure Applicability Validation (MAV) Process**

CMS continues to apply the MAV methodology to individual EPs and group practices that report fewer than nine measures or three domains via claims or qualified registry due to a limited number of clinically-relevant measures. The MAV process analytically determines whether individual EPs or group practices should have reported additional measures or domains. Should CMS determine through the MAV process that an individual EP or group practice could have reported additional measures or domains, the 2017 PQRS payment adjustment may apply.

**Changes to Measures Groups**

Starting in 2015, a minimum number of six measures must be included in a PQRS measures group, up from four in previous years. CMS removed four measures groups and finalized 22 reportable measures groups for 2015.

**Changes to Measures List**

For 2015 reporting, CMS removed 51 measures from the PQRS measures set (Table 55). In addition, CMS finalized 19 cross-cutting measures with additional changes to the reporting mechanisms available per measure (Table 52). For a list of 255 PQRS measures available in 2015, access the [2015 PQRS Measures List](#).
Changes to the PQRS informal review process

CMS modified the deadline to request an informal review of a PQRS penalty to 60 days from the release of the feedback reports, effective starting in 2015. The agency cited efforts to expedite decisions on informal reviews.

As part of the informal review process, CMS allows data resubmission for the purposes of correcting errors if the data is submitted by a third-party vendor on behalf of an EP or group practice using a qualified registry, EHR data submission vendor or QCDR. The agency believes third-party vendors can more easily detect errors than direct users. Data submitted via claims, direct EHR or the GPRO web interface are not eligible for resubmission.

“Extreme and uncontrollable circumstances” meaningful use hardship exception

The 2015 PFS final rule finalized a hardship exception based on “extreme and uncontrollable circumstances” that could potentially provide relief from the 2015 payment adjustment under the Medicare EHR (“Meaningful Use”) Incentive Program for new EPs who had not previously participated in the program. CMS stated that extending the exception application process until Nov. 30, 2014 will afford EPs the opportunity to utilize flexible options recently finalized under the 2014 Certified EHR Technology (CEHRT) Flexibility rule for the 2014 EHR reporting period.

In order to qualify for this exception, the EP must meet two requirements. First, the EP must not have been able to fully implement the 2014 Edition CEHRT due to delays in 2014 Edition CEHRT availability. Second, the provider must not have been able to attest by their attestation deadline in 2014. For example, the EP must not have been able to attest by Oct. 1, 2014 using the flexibility options under the 2014 CEHRT Flexibility rule. The agency reiterated that an extreme and uncontrollable circumstance hardship exception under this final rule applies solely to EPs meeting both these criteria for the 2015 payment adjustment. By extending the hardship exception application deadline to Nov. 30, 2014, CMS was required to amend the current July 1st hardship exception application deadline for extreme and uncontrollable circumstances. To both ensure it does not face similar timing constraints in the future and reduce administrative burden on providers requesting a hardship exception, CMS amended the regulatory text for the other hardship exception categories, allowing the agency to specify a later deadline for submission of hardship exception applications in future years of the program.

Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs)

As part of its goal to align with the PQRS and EHR incentive programs, as well as update ACO quality benchmarking and scoring performance, CMS finalized the following changes to the Medicare Shared Savings Program (MSSP).
MSSP and the Value-Based Payment Modifier (VBPM)

CMS will subject physician EPs who participate in a MSSP-ACO to the 2017 VBPM. (See the VBPM section of this analysis for more details.)

Quality measures and performance standards for MSSP-ACOs

Beginning in 2015, ACOs must meet eight new quality measures in order to share in savings, all with pay-for-reporting requirements in the first year and varying pay-for-performance standards, or phase-in, during the subsequent years of an ACO’s three-year contract with CMS. ACOs in a second or subsequent agreement period for 2015 are subject to pay-for-performance for all three performance years, unless the measure is specifically designated as pay-for-reporting for all three years. This policy applies to measures that have been active for two or more years with established benchmarks. New measures are considered pay-for-reporting during the first two reporting periods of use.

CMS also retired or replaced eight program measures. ACOs are scored for overall quality performance and improvement on a total of 33 quality measures. With these changes, the scoring for each domain and measure has changed.

Alignment with EHR Meaningful Use Clinical Quality Measures (CQMs)

CMS stated its intent for the MSSP program to further align EHR use into quality reporting under the MSSP. The agency codified a new requirement that an EP who is an ACO provider or supplier is able to successfully meet the CQM reporting component of meaningful use when:

1. The EP extracts data needed for the ACO to meet its GPRO quality reporting requirements from CEHRT; and,
2. The ACO successfully reports the ACO’s GPRO measures through the GPRO web interface.

Modifications to the MSSP benchmarking methodology

CMS modified existing rules allowing the agency to update benchmarks every two years to provide ACOs with more stable quality improvement targets and give ACOs a longer period of time to build experience with performance measures.

The agency also finalized its proposal to reward additional quality improvements for ACOs who improve on quality measures within a domain. ACOs are now able to earn an additional four bonus points to be added to the total points within each of the four domains, not to exceed the maximum total points available within each domain. This “improvement change score” is the measure score in one performance year minus the score in a previous performance year, based on an ACO’s net improvement within a domain. (For more information on how CMS will score each measure and domain see Table 82.)
The Value-Based Payment Modifier (VBPM) and Physician Feedback Program

Under the ACA, the Secretary of Health and Human Services is required to apply a VBPM first to specific physicians and groups of physicians the Secretary deems appropriate and ultimately to all Medicare Part B physicians by January 2017. CMS phased-in the VBPM by first applying it to large group practices in 2015 based on 2013 reporting, then to groups with 10 or more EPs in 2016 based on 2014 reporting. The agency must complete the phase-in of the VBPM by applying it to all physicians in 2017 based on 2015 reporting, including those participating in MSSP-ACOs, the Pioneer ACO program, the Comprehensive Primary Care Initiative (CPCI) and other Innovation Center Models.

The VBPM assesses both quality of care furnished and cost of providing that care under the Medicare PFS. The 2017 VBPM is based on 2015 quality and cost performances. CMS estimated the VBPM will impact approximately 900,000 physicians in CY 2017.

VBPM adjustment based on PQRS participation

2017 VBPM quality scores are based on 2015 PQRS reporting. CMS designated two categories of physicians for the purposes of applying the 2017 VBPM.

Category 1: Includes solo practitioners who satisfactorily report PQRS quality measures as individuals and those in group practices that meet the criteria via GPRO for purposes of avoiding the 2017 PQRS payment adjustment during the 2015 reporting year. Additionally includes groups that do not self-nominate through GPRO under PQRS, but have at least 50% of EPs who meet the criteria for satisfactory reporting for PQRS as individuals.

Category 2: Groups and solo practitioners who are subject to the 2017 payment adjustment but do not fall under Category 1.

Quality-Tiering

Quality-tiering grants those in Category 1 the opportunity to earn an upward payment adjustment for providing high quality, low cost care to Medicare beneficiaries as compared with national benchmarks. Conversely, it puts certain groups at risk of receiving downward payment adjustments for providing low quality, low cost care to Medicare beneficiaries.

Under Category 1, CMS applies the quality-tiering methodology to all groups and solo practitioners. Groups with 2-9 EPs and solo practitioners are only subject to upward or neutral adjustments and considered immune to downward adjustments, while groups with 10 or more EPs are subject to upward, neutral or downward adjustments.

Under Category 2, CMS applies a 4% downward payment adjustment to groups with 10 or more EPs and a 2% downward adjustment to groups with 2-9 EPs and solo practitioners. These adjustments are made in addition to the PQRS penalties EPs receive for not successfully reporting in the program.
TABLE 88: Final CY 2017 VM Payment Adjustment Amounts for Groups with Two to Nine Eligible Professionals and Solo Practitioners

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low quality</th>
<th>Average quality</th>
<th>High quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low cost</td>
<td>+0.0%</td>
<td>+1.0x*</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>Average cost</td>
<td>+0.0%</td>
<td>+0.0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>High cost</td>
<td>+0.0%</td>
<td>+0.0%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

* Groups and solo practitioners are eligible for an additional +1.0x if their reporting measures and average beneficiary risk score are both in the top 25% of all beneficiary risk scores, where ‘x’ represents the upward payment adjustment factor.

TABLE 89: Final CY 2017 VM Payment Adjustment Amounts for Groups with Ten or More Eligible Professionals

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low quality</th>
<th>Average quality</th>
<th>High quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low cost</td>
<td>+0.0%</td>
<td>+2.0x*</td>
<td>+4.0x*</td>
</tr>
<tr>
<td>Average cost</td>
<td>-2.0%</td>
<td>+0.0%</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>High cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

* Groups are eligible for an additional +1.0x if their reporting measures and average beneficiary risk score are both in the top 25% of all beneficiary risk scores, where ‘x’ represents the upward payment adjustment factor.

Quality measures

CMS will include all 2015 PQRS quality measures and reporting mechanisms available for both individual and GPRO reporting when calculating the 2017 VBPM.

Clarification Regarding Treatment of Non-Assigned Claims for Non-Participating Physicians

CMS clarified that, starting in 2015, the VBPM will only apply to assigned services, not to non-assigned services to Medicare beneficiaries.

Physician Feedback and Quality Resource Use Reports (QRURs)

CMS stated it plans to make available another round of QRURs based on 2014 reporting in the summer of 2015 for all physicians and groups. CMS provides these confidential feedback reports to groups and physicians in order to communicate the cost and quality resources involved in furnishing care to Medicare FFS beneficiaries within a calendar year. In addition, QRURs are intended to illustrate how a group practice or physician will perform under the VBPM based on the reported quality and cost measures.
While CMS determined it would not be feasible to provide QRURs earlier in the year and still allow sufficient time for claims run out and reporting, the agency may explore options to provide QRURs on a semi-annual basis to enable groups and physicians to better track cost and utilization performance throughout the year.

*Informal inquiry process to allow for corrections under VBPM*

For the 2015 VBPM based on 2013 reporting, CMS established Feb. 28, 2015 as the deadline by which groups may request a correction of any perceived errors in the agency’s determination of its VBPM. Beginning with the 2016 VBPM, a group or solo practitioner must request corrections for perceived errors in their VBPM determination within 60 days following the release of the QRUR.

*National Quality Forum (NQF) concerns regarding total per capita cost measures*

CMS addressed the NQF’s concerns with its ‘two-step’ attribution method within the VBPM by moving nurse practitioners, physician assistants and clinical nurse specialists from Step 2 to Step 1 and removing the “pre-step.” The agency believes this move will streamline the attribution process and ensure beneficiaries can be assigned to group practices comprised of non-physician EPs.

*Application of the VBPM for non-physician EPs*

Beginning in 2018, the VBPM applies to non-physician solo practitioners and non-physician EPs in groups of two or more, including groups comprised only of non-physician EPs, such as nurse practitioner or physician assistant groups. Non-physician EPs who participate in MSSP ACOs are also subject to the VBPM in 2018.