

# Issue Brief

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## KEY POINTS

- CMS final payment and policy updates include:
  - Updates to the relative value units
  - Incident to proposals
  - Phase-in of significant RVU reductions
  - Therapy caps
  - Updates because of legislative activities such as the Protecting Access to Medicare Act of 2014 and the Medicare Access and CHIP Reauthorization Act of 2015
  - Value-based modifier revisions

## CMS Issues Final Changes to the MPFS and Other Part B Services for CY 2016

The Centers for Medicare & Medicaid Services has issued a final rule regarding revisions to payment policies and payment rates under the Medicare Physician Fee Schedule for calendar year 2016. A copy of the document is available on the Federal Register website at <https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-28005.pdf>. The rule is scheduled for publication on Nov. 16.

The PFS addenda along with other supporting documents and tables referenced in this final rule are available on CMS' website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFSFederal-Regulation-Notices.html>. Click on the link on the left side of the screen titled "PFS Federal Regulations Notices," for a chronological list of PFS Federal Register and other related documents. For the CY 2016 PFS final rule with comment period, refer to item CMS-1631-FC.

## COMMENT

The rule's table of contents provides a concise list of items being addressed in the document.

### Provisions for PFS

- A. Determination of Practice Expense Relative Value Units
- B. Determination of Malpractice Relative Value Units
- C. Elimination of the Refinement Panel
- D. Improving Payment Accuracy for Primary Care and Care Management Services
- E. Target for Relative Value Adjustments for Misvalued Services
- F. Phase-in of Significant RVU Reductions
- G. Changes for Computed Tomography under the Protecting Access to Medicare Act of 2014
- H. Valuation of Specific Codes
  - I. Medicare Telehealth Services
  - J. Incident to Proposals: Billing Physician as the Supervising Physician and Ancillary Personnel Requirements
  - K. Portable X-ray: Billing of the Transportation Fee
  - L. Technical Correction: Waiver of Deductible for Anesthesia Services Furnished on the Same Date as a Planned Screening Colorectal Cancer Test
  - M. Therapy Caps

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continued

## Other Provisions

- A. Provisions Associated with the Ambulance Fee Schedule
- B. Chronic Care Management Services for Rural Health Clinics and Federally Qualified Health Centers
- C. Healthcare Common Procedure Coding System Coding for Rural Health Clinics
- D. Payment to Grandfathered Tribal FQHCs That Were Provider-Based Clinics on or Before April 7, 2000
- E. Part B Drugs — Biosimilars
- F. Productivity Adjustment for the Ambulance, Clinical Laboratory, and DMEPOS Fee Schedules
- G. Appropriate Use Criteria for Advanced Diagnostic Imaging Services
- H. Physician Compare Website
- I. Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System
- J. Electronic Clinical Quality Measures and Certification Criteria and Electronic Health Record Incentive Program— Comprehensive Primary Care Initiative and Medicare Meaningful Use Aligned Reporting
- K. Discussion and Acknowledgement of Public Comments Received on the Potential Expansion of the Comprehensive Primary Care Initiative
- L. Medicare Shared Savings Program
- M. Value-Based Payment Modifier and Physician Feedback Program
- N. Physician Self-Referral Updates
- O. Private Contracting/Opt-Out
- P. Physician Self-Referral Prohibition: Annual Update to the List of CPT/HCPCS

As always the MPFS rule is long, complex and coding intensive. This version is 1,358 pages whereas the proposed rule was 815 pages. Again, there is much material on the continued emphasis and data requirements for quality reporting. And, again there is much history being repeated in numerous sections.

## RECENT LEGISLATIVE ITEMS

The following legislative changes weigh on numerous items being addressed.

Section 220(d) of the Protecting Access to Medicare Act of 2014, enacted on April 1, 2014, added a new subparagraph (O) to section 1848(c)(2) of the Act to establish an annual target for reductions in PFS expenditures resulting from adjustments to relative values of misvalued codes. The PAMA originally applied the target to CYs 2017 through 2020 and set the target amount to 0.5 percent of the estimated amount of expenditures under the PFS for each of those 4 years.

Section 202 of the Achieving a Better Life Experience Act of 2014, enacted Dec. 19, 2014, accelerated the application of the target to specify that targets would apply for CYs 2016, 2017 and 2018 and set a 1 percent target for CY 2016 and 0.5 percent for CYs 2017 and 2018.

The Medicare Access and CHIP Reauthorization Act of 2015 enacted on April 16, 2015, makes several changes to the statute, including, but not limited to the following.

1. Repealing the sustainable growth rate update methodology for physicians' services.
2. Revising the PFS update for 2015 and subsequent years.
3. Establishing a Merit-based Incentive Payment System under which eligible professionals (initially including physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists) receive annual payment increases or decreases based on their performance in a prior period.
4. Prohibiting the Secretary from implementing the policy established

in the CY 2015 PFS final rule that would have transitioned all 10-day and 90-day global surgery packages to 0-day global periods.

## CONVERSION FACTOR

The conversion factor details are located in the rule’s regulatory impact analysis. CMS estimates the CY 2016 PFS conversion factor to be \$35.8279, which reflects a budget neutrality adjustment, the 0.5 percent update adjustment factor specified under the MACRA, and a 0.77 percent target recapture amount required under Section 1848(c)(2)(O)(iv) of the Act (misvalued target correction shortfall). CMS estimates the CY 2016 anesthesia conversion factor to be \$22.3309, which reflects the same adjustments, with the addition of anesthesia-specific PE and MP adjustments.

Calculation of the CY 2016 PFS Conversion Factor		
Conversion Factor in Effect in CY 2015		35.9335
Update Factor	0.5 percent (1.005)	
CY 2016 RVU Budget Neutrality Adjustment	-0.02 percent (0.9998)	
CY 2016 Target Recapture Amount	-0.77 percent (0.9923)	
<b>CY 2016 Conversion Factor</b>		<b>\$35.8279</b>

Calculation of the CY 2016 Anesthesia Conversion Factor		
CY 2015 National Average Anesthesia Conversion Factor		22.6093
CY 2016 RVU Budget Neutrality Adjustment	-0.02 percent (0.9998)	
CY 2016 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	-0.445 percent (0.99555)	
CY 2016 Target Recapture Amount	-0.79 percent (0.9923)	
<b>CY 2016 Conversion Factor</b>		<b>\$22.3309</b>

## COMMENT

Note, both conversion factors are less than the current 2015 values.

## I. PROVISIONS OF THE FINAL RULE REGARDING PFS

### A. Determination of Practice Expense Relative Value Units

Practice expense is the portion of the resources used in furnishing a service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages, but excluding malpractice expenses.

This section of the rule addresses a number of items relating to the proper identification of costs, both direct and indirect, to be used in determining practice expense items. Most involve small changes.

The PE RVUs in Addendum B reflect 2016 refinements to the PE methodology.

CMS is making a number of adjustments as follows.

- CMS is finalizing its proposal to update the price for the Picture Archiving and Communication System workstation to \$5,557 from the current price of \$2,501.
- CMS is finalizing standard times for clinical labor tasks associated with digital imaging at two minutes for “Availability of prior images confirmed,” two minutes for “Patient clinical information and questionnaire reviewed by technologist, order from physician confirmed and exam protocolled by radiologist,” two minutes for “Review examination with interpreting MD,” and one minute for “Exam documents scanned into PACS.”
- CMS is finalizing standard times for clinical labor tasks associated with pathology services at four minutes for “Accession specimen/prepare for examination,” 0.5 minutes for “Assemble and deliver slides with paperwork to pathologists,” 0.5 minutes for “Assemble other light microscopy slides, open nerve biopsy slides, and clinical history, and present to pathologist to prepare clinical pathologic interpretation,” one minute for “Clean room/equipment following procedure,” one minute for “Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste,” and one minute for “Prepare, pack and transport specimens and records for in-house storage and external storage (where applicable).”
- CMS is finalizing the proposal to eliminate the minutes assigned for the task “complete Botox log” from the direct PE input database.
- CMS will add clinical labor time missing from CPT codes 22510 and CPT code 22511.

- CMS will create a supply item for Spherusol and included as a direct PE input for CPT code 86490.
- CMS will change the price for EQ340 (Patient Worn Telemetry System) to \$23,537.

## **B. Determination of Malpractice Relative Value Units**

CMS will conduct annual MP RVU updates to reflect changes in the mix of practitioners providing services and to adjust MP RVUs for risk, and to modify the specialty mix assignment methodology to use an average of the three most recent years of available data instead of a single year. CMS says that it will continue to maintain code-specific overrides where the claims data are inconsistent with a specialty that would reasonably be expected to furnish the services.

For CY 2016, to appropriately update the MP resource costs for anesthesia, CMS will make adjustments to the anesthesia conversion factor to reflect updated premium information collected for the five-year review.

## **C. Refinement Panel**

For CY 2016, CMS proposed to permanently eliminate the refinement panel that was established in 1993, and instead publish proposed rates for all interim final codes in the PFS proposed rule for the subsequent year. CMS is not adopting this proposal.

## **D. Improving Payment Accuracy for Primary Care and Care Management Services**

In the CY 2016 PFS proposed rule, CMS sought public comment on a number of issues regarding payment for primary care and care coordination under the PFS.

While CMS received comments, no actions are being taken at this time.

### **E. Target for Relative Value Adjustments for Misvalued Services, and**

### **F. Phase-in of Significant RVU Reductions**

Section 1848(c)(2)(K) of the Act requires the Secretary to periodically identify potentially misvalued services using certain criteria and to review and make appropriate adjustments to the relative values for those services.

CMS has now identified 103 codes (down from 118 in the proposed rule) listed in the rule's Table 8 as potentially misvalued codes, identified using a high expenditure screen under the statutory category, "codes that account for the majority of spending under the PFS." This list is not all-inclusive. CMS has also identified other possible misvalued codes.

The statute requires that if the net reductions in misvalued codes in 2016 are not equal to or greater than 1.0 percent of the estimated expenditures under the fee schedule, a reduction equal to the percentage difference between 1.0 percent and the estimated net reduction in expenditures resulting from misvalued code reductions must be made to all PFS services.

PAMA Section 220(e) specifies that for services that are not new or revised codes, if the total RVUs for a service for a year would otherwise be decreased by an estimated 20 percent or more as compared to the total RVUs for the previous year, the applicable adjustments in work, PE, and MP RVUs shall be phased-in over a two-year period. Although section 220(e) of the PAMA required the phase-in to begin for 2017, section 202 of the ABLE Act amended section 1848(c)(7)

of the Act to require that the phase-in begin for CY 2016.

To comply with the above two-year phase-in, CMS will reduce the service by 19 percent in the first year, and then phase in the remainder of the reduction in the second year. Under this approach, the code that is reduced by 19 percent in a year and the code that would otherwise have been reduced by 20 percent would both be reduced by 19 percent in the first year, and the latter code would see an additional 1 percent reduction in the second year of the phase-in. For most services, this would likely mean that the majority of the reduction would take place in the first year of the phase-in. However, for services with the most drastic reductions (greater than 40 percent), the majority of the reduction would not take place in the first year of the phase-in.

The list of codes subject to the phase-in and the associated RVUs that result from this methodology are available on CMS' website under downloads for the CY 2016 PFS final rule with comment period at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html>.

### **COMMENT**

The following is a comment to CMS' proposed PFS rule regarding reductions from misvalued RVUs that is right on the money. "Another commenter stated that the proposed net reduction in expenditures of 0.25 percent, as opposed to 1.00, means that the 0.75 percent difference will come from the conversion factor, and doing so would more than negate the 0.5 percent increase physicians were promised under MACRA." The reduction for 2016 is seen above in the calculation of the conversion factor.

## **G. Changes for Computed Tomography under the Protecting Access to Medicare Act of 2014 (CY 2016 only)**

Section 218(a) of PAMA is entitled “Quality Incentives To Promote Patient Safety and Public Health in Computed Tomography Diagnostic Imaging.” It amends the statute by reducing payment for the technical component (TC) (and the TC of the global fee) of the PFS service and the hospital outpatient prospective payment system (OPPS) payment (5 percent in 2016 and 15 percent in 2017 and subsequent years) for computed tomography (CT) services identified by CPT codes 70450-70498, 71250-71275, 72125-72133, 72191-72194, 73200-73206, 73700-73706, 74150-74178, 74261-74263, and 75571-75574 furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013, entitled “Standard Attributes on CT Equipment Related to Dose Optimization and Management.”

Beginning in 2016, claims for CT scans described by the above-listed CPT codes (and any successor codes) that are furnished on non-NEMA Standard XR-29-2013-compliant CT scans must include modifier “CT” and that modifier will result in the applicable payment reduction for the service.

## **H. Valuation of Specific Codes**

CMS notes that establishing valuations for newly created and revised CPT codes is a routine part of maintaining the PFS.

For CY 2016, CMS is adopting new values for the codes for which it received complete American Medical Association/ Specialty Society Relative (Value) Update Committee recommendations by Feb. 10, 2015.

Beginning with valuations for CY 2017, a new process will be applicable to all codes. That is, beginning with rulemaking for CY 2017, CMS will propose values for the vast majority of new, revised, and potentially misvalued codes and consider public comments before establishing final values for the codes; use G-codes as necessary to facilitate continued payment for certain services for which the agency does not receive recommendations in time to propose values; and adopt interim final values in the case of wholly new services for which there are no predecessor codes or values and for which CMS does not receive recommendations in time to propose values.

## **CY 2016 Valuation Specific Codes and Sections**

The rule’s Table 11 that includes the “CY 2016 Work RVUs for New, Revised and Potentially Misvalued Codes with Proposed Values in the CY 2016 PFS Proposed Rule.”

Other material discussed:

- a. Lower GI Endoscopy Services (commencing on the rule’s page 199)
- b. Radiation Treatment and Related Image Guidance Services (page 215)
- c. Advance Care Planning Services (page 240)
- d. Valuation of Other Codes for CY 2016 (page 255)

## **Direct PE Input-Only Recommendations**

CMS notes that the RUC-recommended direct PE inputs for a series of services. These items include:

- a. Repair of Nail Bed (CPT Code 11760);
- b. Simple Repair of Superficial Wounds (CPT Codes 12005, 12006, 12007, 12013, 12014, 12015, and 12016);

- c. Intermediate Repair of Wounds (CPT Codes 12041, 12054, 12055, and 12057);
- d. Nasal or Sinus Surgical Endoscopy (CPT Codes 31295, 31296, and 31297);
- e. Removal of Embedded Foreign Body from Mouth and Pharynx (CPT Codes 40804 and 42809);
- f. Cytopathology Fluids, Washings or Brushings and Cytopathology Smears, Screening, and Interpretation (CPT Codes 88104, 88106, 88108, 88112, 88160, 88161, and 88162);
- g. Flow Cytometry, Cell Cycle or DNA Analysis (CPT Code 88182);
- h. Flow Cytometry, Cytoplasmic Cell Surface (CPT Codes 88184 and 88185);
- i. Consultation on Referred Slides and Materials (CPT Codes 88321, 88323, and 88325);
- j. Pathology Consultation during Surgery (CPT Codes 88329, 88331, 88332, 88333, and 88334);
- k. Morphometric Analysis (CPT Code 88355);
- l. Morphometric Analysis, Tumor Immunohistochemistry (CPT Codes 88360 and 88361);
- m. Nerve Teasing Preparations (CPT Code 88362);
- n. Nasopharyngoscopy with Endoscope (CPT Code 92511);
- o. EEG Extended Monitoring (CPT Codes 95812 and 95813);
- p. Testing of Autonomic Nervous System Function (CPT Code 95923);
- q. Central Motor Evoked Study (CPT Codes 95928 and 95929); and,
- r. Blink Reflex Test (CPT Code 95933)

### CY 2015 Interim Final Codes

CMS discusses each code for which it received a comment on the CY 2015 interim final work RVU or work time during the comment period for the CY 2015 final rule or for which it is modifying the CY 2015 interim final work RVU, work time or procedure status indicator for CY 2016.

The material identifying some 248 CPT codes is provided in the rule's table 13. CMS also addresses specific issues for many of these items.

### CY 2016 Interim Final Codes

For recommendations regarding any new or revised codes received after the Feb. 10, 2015, deadline, including updated recommendations for codes included in the CY 2016 proposed rule, CMS is establishing interim final values in this final rule consistent with previous practice.

The rule's Table 15: "CY 2016 Interim Final Work RVUs for New/Revised or Potentially Misvalued Codes" and table 16: "CY 2016 Interim Final Codes with Direct PE Input Recommendations Accepted With Refinements" include a list of these codes.

### COMMENT

**This is a long and detailed section — some 307 pages — including changes to many codes and the final determination of many RVUs.**

### I. Medicare Telehealth Services

CMS will add the following services to the telehealth list on a category 1 basis for CY 2016:

- CPT code 99356 (prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient

evaluation and management service); and 99357 (prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service).

- CPT codes 90963 (end-stage renal disease related services for home dialysis per full month, for patients younger than two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents); 90964 (end-stage renal disease related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents); 90965 (end-stage renal disease related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents); and 90966 (end stage renal disease related services for home dialysis per full month, for patients 20 years of age and older).

#### **J. Incident to Proposals: Billing Physician as the Supervising Physician and Ancillary Personnel Requirements**

CMS proposed to amend §410.26(b)(5) to state that the physician or other practitioner who bills for incident to services must also be the physician or other practitioner who directly supervises the auxiliary personnel who provide the incident to services. Also, to further clarify the meaning of the proposed amendment to this regulation, CMS proposed to remove the last sentence from §410.26(b)(5) specifying that the physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other

practitioner) upon whose professional service the incident to service is based.

CMS is finalizing the changes to its regulation at §410.26(a)(1) without modification, and is finalizing the proposed change to the regulation at §410.26(b)(5) with a clarifying modification. Specifically, CMS is amending the definition of the term, “auxiliary personnel” at §410.26(a)(1) that are permitted to provide “incident to” services to exclude individuals who have been excluded from the Medicare program or have had their Medicare enrollment revoked. Additionally, CMS is amending §410.26(b)(5) by revising the final sentence to make clear that the physician (or other practitioner) directly supervising the auxiliary personnel need not be the same physician (or other practitioner) that is treating the patient more broadly, and adding a sentence to specify that only the physician (or other practitioner) that supervises the auxiliary personnel that provide incident to services may bill Medicare Part B for those incident to services.

#### **K. Portable X-ray: Billing of the Transportation Fee**

Portable X-ray suppliers receive a transportation fee for transporting portable X-ray equipment to the location where portable X-rays are taken.

CMS will revise the Medicare Claims Processing Manual (Pub. 100-4, Chapter 13, Section 90.3) to remove the word “Medicare” before “patient” in section 90.3. CMS will also clarify that this sub-regulatory guidance means that, when more than one patient is X-rayed at the same location, the single transportation payment under the PFS is to be prorated among all patients (Medicare Parts A and B, and non-Medicare) receiving portable X-ray services during that trip, regardless of their insurance status.

## II. OTHER PROVISIONS OF THE REGULATIONS

### A. Provisions Associated With the Ambulance Fee Schedule

Under the ambulance fee schedule, the Medicare program pays for ambulance transportation services for Medicare beneficiaries when other means of transportation are contraindicated by the beneficiary's medical condition and all other coverage requirements are met.

CMS will apply a 22.6 percent rural bonus to ground ambulance services with dates of service before Jan. 1, 2018, where transportation originates in a qualified rural area.

CMS will continue implementation of the new OMB delineations as described in the Feb. 28, 2013, OMB Bulletin No. 13-01 for CY 2016 and subsequent CYs to more accurately identify urban and rural areas for ambulance fee schedule payment purposes.

CMS will revise §410.41(b) to require all Medicare-covered ambulance transports must be staffed by at least two people who meet both the requirements of applicable state and local laws where the services are being furnished, and the current Medicare requirements under §410.41(b).

### B. Chronic Care Management Services for Rural Health Clinics and Federally Qualified Health Centers

CMS will, as proposed, provide an additional payment for the costs of CCM services that are not already captured in the RHC all-inclusive rate or the FQHC PPS payment, beginning Jan. 1, 2016. Services that are currently being furnished and paid under the RHC AIR or FQHC PPS payment methodology will not be affected by the ability of the RHC or FQHC to receive payment for

additional services that are not included in the RHC AIR or FQHC PPS.

The requirements for RHCs and FQHCs to receive payment for CCM services are consistent with those finalized in the CY 2015 PFS final rule for practitioners billing under the PFS and are summarized in the rule's Table 24.

### C. Healthcare Common Procedure Coding System Coding for Rural Health Clinics

CMS will require all RHCs must report all services furnished during an encounter using standardized coding systems, such as level I and level II HCPCS codes, for dates of service beginning April 1, 2016.

### D. Payment to Grandfathered Tribal FQHCs That Were Provider-Based Clinics on or Before April 7, 2000

CMS will adopt its proposal that IHS and tribal facilities and organizations that met the conditions of section 413.65(m) on or before April 7, 2000, and have a change in their status on or after April 7, 2000, from IHS to tribal operation, or vice versa, or the realignment of a facility from one IHS or tribal hospital to another IHS or tribal hospital such that the organization no longer meets the CoPs, may seek to become certified as grandfathered tribal FQHCs.

### E. Part B Drugs

The FDA approved the first biosimilar product under the new biosimilar approval pathway required by the ACA on March 6, 2015. CMS will, as proposed, update the regulations to clarify that the payment amount for a billing code that describes a biosimilar biological drug product is based on the average sales price of all biosimilar biological products that reference a common biological product's license application.

## **F. Productivity Adjustment for the Ambulance, Clinical Laboratory, and DMEPOS Fee Schedules**

Beginning with CY 2016, for the AFS, CLFS and DMEPOS fee schedule, the MFP adjustment is calculated using a revised series developed by IGI to proxy the aggregate capital inputs.

A complete description of the MFP projection methodology is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.html>.

## **G. Appropriate Use Criteria for Advanced Diagnostic Imaging Services**

Section 218(b) of the PAMA amended Title XVIII of the Act to add section 1834(q) directing CMS to establish a program to promote the use of appropriate use criteria for advanced diagnostic imaging services. CMS says that this rule outlines the initial component of the new Medicare AUC program and CMS' plan for implementing the remaining components. The material is nearly 50 pages in length.

There are four major components of the AUC program under section 1834(q) of the Act, each with its own implementation date: (1) establishment of AUC by Nov. 15, 2015 (section 1834(q)(2)); (2) mechanisms for consultation with AUC by April 1, 2016 (section 1834(q)(3)); (3) AUC consultation by ordering professionals and reporting on AUC consultation by furnishing professionals by Jan. 1, 2017 (section 1834(q)(4)); and (4) annual identification of outlier ordering professionals for services furnished after Jan. 1, 2017 (section 1834(q)(5)).

In the proposed rule, CMS primarily addressed the first component under section 1834(q)(2) — the process for establishment of AUC, along with relevant aspects of the definitions under section 1834(q)(1).

CMS is providing definitions for areas of the statute that require clarification. For example, a definition is required for “provider-led entity” to identify which organizations are eligible to develop or endorse appropriate use criteria. CMS is modifying the proposed definition of PLE to finalize a definition that focuses on the practitioners and providers that comprise an organization and not on whether the organization, as an entity, delivers care.

CMS is finalizing its proposed deadline of Jan. 1, 2016, for PLEs to apply to become qualified PLEs because CMS says it is important that to avoid further delay of AUC specification and program implementation.

## **H. Physician Compare Website**

The rule's Table 25 provides a summary of previously finalized policies for public reporting data on Physician Compare.

The rule's Table 26 summarizes the rule's Measure and Participation Data Public Reporting.

Data Collection Year*	Publication Year*	Data Type	Reporting Mechanism	Quality Measures and Data Finalized for Public Reporting
2016	2017	PQRS, PQRS GPRO, EHR, and Million Hearts	Web Interface, EHR, Registry, Claims	Include an indicator for satisfactory reporters under PQRS, participants in the EHR Incentive Program, and EPs who satisfactorily report the Cardiovascular Prevention measures group under PQRS in support of Million Hearts.
2016	2017	PQRS GPRO	Web Interface, EHR, Registry	All PQRS GPRO measures reported via the Web Interface, EHR, and registry that are available for public reporting for group practices of 2 or more EPs. Publicly report an item-level benchmark, as appropriate.
2016	2017	ACO	Web Interface, Survey Vendor Claims	All measures reported by Shared Savings Program ACOs, including CAHPS for ACOs.
2016	2017	CAHPS for PQRS	CMS-Specified Certified CAHPS Vendor	All CAHPS for PQRS measures for groups of 2 or more EPs who meet the specified sample size requirements and collect data via a CMS-specified certified CAHPS vendor.
2016	2017	PQRS	Registry, EHR, or Claims	All PQRS measures for individual EPs collected through a registry, EHR, or claims. Publicly report an item-level benchmark, as appropriate.
2016	2017	QCDR data	QCDR	All individual EP and group practice QCDR measures.
2016	2017	Utilization data	Claims	Utilization data for individual EPs in the downloadable database.
2016	2017	PQRS, PQRS GPRO	Web Interface, EHR, Registry, Claims	The following data for group practices and individual EPs in the downloadable database: <ul style="list-style-type: none"> <li>• The VM quality tiers for cost and quality, noting if the group practice or EP is high, low, or neutral on cost and quality per the VM.</li> <li>• A notation of the payment adjustment received based on the cost and quality tiers.</li> </ul> An indication if the individual EP or group practice was eligible to but did not report quality measures to CMS.

\* Note that these data are finalized to be reported annually. The table only provides the first year in which these data would begin on an annual basis, and such dates also serve to illustrate the data collection year in relation to the publication year.

Therefore, after 2016, 2017 data would be publicly reported in 2018, 2018 data would be publicly reported in 2019, etc.

## **I. Physician Payment, Efficiency, and Quality Improvements — Physician Quality Reporting System**

This section includes the requirements for the Physician Quality Reporting System.

CMS notes that section 101(b)(2)(A) of MACRA amends section 1848(a)(8)(A) by striking “2015 or any subsequent year” and inserting “each of 2015 through 2018.” This amendment authorizes the end of the PQRS in 2018 and beginning of a new program, which may incorporate aspects of the PQRS, the Merit-based Incentive Payment System.

There will be 281 measures in the PQRS measure set and 18 measures in the GPRO web interface for 2016.

If an eligible professional does not satisfactorily report data on quality measures for covered professional services for the quality reporting period for the year, the fee schedule amount for services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services. For 2016 and subsequent years, the applicable percent is 98 percent. In other words, failure to report quality data will result in a 2 percent payment reduction.

EPs in CAH-IIs may participate in the PQRS using ALL reporting mechanisms available, including the claims-based reporting mechanism.

EPs who practice in RHCs and/or FQHCs would not be subject to the PQRS payment adjustment.

Claims submitted for services performed by EPs who perform services as employees of, or on a reassignment basis to, IDTFs or ILs would not be subject to the PQRS payment adjustment.

CMS will open the QCDR self-nomination period on Dec. 1 of the prior year to allow more time for entities to self-nominate.

The rule’s Tables 27 and 28 reflect CMS’ criteria for satisfactory reporting – or, in lieu of satisfactory reporting, satisfactory participation in a QCDR – for the 2018 PQRS payment adjustment.

**TABLE 27: Summary of Requirements for the 2018 PQRS Payment Adjustment: Individual Reporting Criteria for the Satisfactory Reporting of Quality Measures Data via Claims, Qualified Registry, and EHRs and Satisfactory Participation Criterion in QCDRs**

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting/Satisfactory Participation Criteria
12-month (Jan 1– Dec 31, 2016)	Individual Measures	Claims	Report at least nine measures, covering at least three of the NQS domains AND report each measure for at least 50 percent of the EP’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the EP sees at least one Medicare patient in a face-to-face encounter, the EP will report on at least one measure contained in the PQRS crosscutting measure set. If less than nine measures apply to the EP, the EP would report on each measure that is applicable), AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.
12-month (Jan 1– Dec 31, 2016)	Individual Measures	Qualified Registry	Report at least nine measures, covering at least three of the NQS domains AND report each measure for at least 50 percent of the EP’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the EP sees at least one Medicare patient in a face-to-face encounter, the EP will report on at least one measure contained in the PQRS crosscutting measure set. If less than nine measures apply to the EP, the EP would report on each measure that is applicable, AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.
12-month (Jan 1– Dec 31, 2016)	Individual Measures	Direct EHR Product or EHR Data Submission Vendor Product	Report nine measures covering at least three of the NQS domains. If an EP’s direct EHR product or EHR data submission vendor product does not contain patient data for at least nine measures covering at least three domains, then the EP would be required to report all of the measures for which there is Medicare patient data. An EP would be required to report on at least one measure for which there is Medicare patient data.
12-month (Jan 1– Dec 31, 2016)	Measures Groups	Qualified Registry	Report at least one measures group AND report each measures group for at least 20 patients, the majority (11 patients) of which are required to be Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted.
12-month (Jan 1– Dec 31, 2016)	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR	Qualified Clinical Data Registry (QCDR)	Report at least nine measures available for reporting under a QCDR covering at least three of the NQS domains, AND report each measure for at least 50 percent of the EP’s patients. Of these measures, the EP would report on at least two outcome measures, OR, if two outcomes measures are not available, report on at least one outcome measures and at least one of the following types of measures — resource use, patient experience of care, efficiency/appropriate use, or patient safety.

**TABLE 28: Summary of Requirements for the 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO**

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1– Dec 31, 2016)	25— 99 EPs; 100+ EPs (if CAHPS for PQRS does not apply)	Individual GPRO Measures in the GPRO Web Interface	Web Interface	Report on all measures included in the web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group’s sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100 percent of assigned beneficiaries. In other words, we understand that, in some instances, the sampling methodology we provide will not be able to assign at least 248 patients on which a group practice may report, particularly those group practices on the smaller end of the range of 25–99 EPs. If the group practice is assigned less than 248 Medicare beneficiaries, then the group practice must report on 100 percent of its assigned beneficiaries. A group practice must report on at least one measure for which there is Medicare patient data.
12-month (Jan 1– Dec 31, 2016)	25— 99 EPs that elect CAHPS for PQRS; 100+ EPs (if CAHPS for PQRS applies)	Individual GPRO Measures in the Web Interface + CAHPS for PQRS	Web Interface + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor. In addition, the group practice must report on all measures included in the web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group’s sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100 percent of assigned beneficiaries. A group practice will be required to report on at least 1 measure for which there is Medicare patient data.  Please note that, if the CAHPS for PQRS survey is applicable to a group practice who reports quality measures via the web interface, the group practice must administer the CAHPS for PQRS survey in addition to reporting the web interface measures.
12-month (Jan 1– Dec 31, 2016)	2— 99 EPs; 100+ EPs (if CAHPS for PQRS does not apply)	Individual Measures	Qualified Registry	Report at least nine measures, covering at least three of the NQS domains. Of these measures, if a group practice sees at least one Medicare patient in a face-to-face encounter, the group practice would report on at least one measure in the PQRS crosscutting measure set. If less than nine measures covering at least three NQS domains apply to the group practice, the group practice would report on each measure that is applicable to the group practice, AND report each measure for at least 50 percent of the group’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.
12-month (Jan 1– Dec 31, 2016)	2— 99 EPs that elect CAHPS for PQRS 100+ EPs (if CAHPS for PQRS applies)	Individual Measures + CHAPS for PQRS	Qualified Registry + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least six additional measures, outside of the CAHPS for PQRS survey, covering at least two of the NQS domains using the qualified registry. If less than six measures apply to the group practice, the group practice must report on each measure that is applicable to the group practice. Of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, if any EP in the group practice sees at least one Medicare patient in a face-to-face encounter, the group practice must report on at least one measure in the PQRS cross-cutting measure set.

**TABLE 28: Summary of Requirements for the 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO**

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1– Dec 31, 2016)	2– 99 EPs; 100+ EPs (if CAHPS for PQRS does not apply)	Individual Measures	Direct EHR Product or EHR Data Submission Vendor Product	Report nine measures covering at least three domains. If the group practice’s direct EHR product or EHR data submission vendor product does not contain patient data for at least nine measures covering at least three domains, then the group practice must report all of the measures for which there is Medicare patient data. A group practice must report on at least one measure for which there is Medicare patient data.
12-month (Jan 1– Dec 31, 2016)	2+ EPs that elect CAHPS for PQRS 100+EPs (if CHAPS for PQRS applies)	Individual Measures + CAHPS for PQRS	Direct EHR Product or EHR Data Submission Vendor Product + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS- certified survey vendor, and report at least six additional measures, outside of CAHPS for PQRS, covering at least two of the NQS domains using the direct EHR product or EHR data submission vendor product. If less than six measures apply to the group practice, the group practice must report all of the measures for which there is Medicare patient data. Of the additional six measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, a group practice would be required to report on at least one measure for which there is Medicare patient data.
12-month (Jan 1– Dec 31, 2016)	2+ EPs	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR	Qualified Clinical Data Registry (QCDR)	Report at least nine measures available for reporting under a QCDR covering at least three of the NQS domains, AND report each measure for at least 50 percent of the group practice’s patients. Of these measures, the group practice would report on at least two outcome measures, OR, if two outcomes measures are not available, report on at least one outcome measures and at least one of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety.

In the CY 2015 PFS final rule with comment period, CMS finalized a set of 19 cross-cutting measures for reporting in the PQRS for 2015 and beyond.

The current PQRS crosscutting measure set is available at [http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015\\_PQRS\\_CrosscuttingMeasures\\_12172014.pdf](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_CrosscuttingMeasures_12172014.pdf). A summary of the comments, responses, as well as final decisions on the 2016 crosscutting measures are located in the rule’s Table 29 (beginning on page 797 of the display copy).

The rule’s Table 30 includes additional measures to be included in the PQRS measure set for CY 2016 and beyond (beginning on page 800).

In Table 31, CMS provides its proposals and those finalized for a NQS domain change for measures that are currently available for reporting under the PQRS. (page 836)

In Table 32, CMS provides its proposals and those finalized measures to be removed from reporting under the PQRS. (page 838)

Table 33 includes: Existing Individual Quality Measures and those Included in Measures Groups for the PQRS for Which Measure Reporting Updates Will Be Effective Beginning in 2016. (page 845)

Table 34 includes: Cardiovascular Prevention Measures Group for 2016 and Beyond (Millions Hearts) (page 856).

Table 35 includes: Diabetic Retinopathy Measures Group for 2016 and Beyond (page 856).

Table 36 includes: Multiple Chronic Conditions Measures Group for 2016 and Beyond (page 857). CMS will add, as proposed, measure groups contained in the following tables.

Table 37: Coronary Artery Bypass Graft (CABG) Measures Group for 2016 and Beyond (page 859).

Table 38: Dementia Measures Group for 2016 and Beyond (CMS is finalizing its proposal to add PQRs# 134 Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan and delete PQRs #285 Dementia: Screening for Depressive Symptoms from this measures group (page 861).

Table 39: Diabetes Measures Group for 2016 and Beyond (CMS is finalizing its proposal to add PQRs #126 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy and delete PQRs #163 Diabetes: Foot Exam from this measures group (page 863).

Table 40: Preventive Care Measures Group for 2016 and Beyond (CMS is finalizing its proposal to add NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling and delete PQRs #173 Preventive Care and Screening: Unhealthy Alcohol Use – Screening from this measures group for 2016 PQRs (page 864).

Table 41: Rheumatoid Arthritis Measures Group For 2016 and Beyond (CMS is finalizing its proposal to add PQRs #337 Tuberculosis Prevention

for Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier to this measures group for 2016 PQRs (page 866).

The current listing of measures by specialty can be found at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>.

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## COMMENT

This is a detailed and complex section with many tables. Perhaps the single most helpful table is Table 43, which contains The FINAL list of all PQRS measures available for reporting in 2016 (beginning page 870 and extending some 33 pages through page 913).

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## The Merit-based Incentive Payment System

Section 1848(q) of the Act, added by section 101(c) of the MACRA, requires creation of the MIPS, applicable beginning with payments for items and services furnished on or after Jan. 1, 2019, under which the Secretary shall: (1) develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards for a performance period for a year; (2) using the methodology, provide for a composite performance score for each eligible professional for each performance period; and (3) use the composite performance score of the MIPS eligible professional for a performance period for a year to determine and apply a MIPS adjustment factor (and, as applicable, an additional MIPS adjustment factor) to the professional for the year.

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## COMMENT

While CMS says more than 90 comments were received, it says no more.

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### **J. Electronic Clinical Quality Measures and Certification Criteria; and Electronic Health Record Incentive Program- Comprehensive Primary Care Initiative and Medicare Meaningful Use Aligned Reporting**

CMS will retain the group reporting option for CPC practice sites as finalized in the CY 2015 PFS final rule, but for CY 2016, require CPC practice sites to submit at least 9 CPC CQMs that cover 3 domains. CMS will allow, as proposed, EPs who are part of CPC practice site and are in their first year of demonstrating meaningful use may also use this CPC group reporting option to report their CQMs electronically instead of reporting CQMs by attestation through the EHR Incentive Program's Registration and Attestation System.

### **K. Potential Expansion of the Comprehensive Primary Care Initiative**

The CPC initiative is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. It is being conducted under the authority of section 1115A of the Act (added by section 3021 of the ACA). There are approximately 480 participating practices spread across the regions, and 38 participating payers.

### **COMMENT**

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CMS says it received more than 90 comments in response to its request for such. Nothing more is said at this juncture.

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### **L. Medicare Shared Savings Program**

Section 1899(b)(3)(C) of the Act requires the Secretary to establish quality performance standards to assess the quality of care furnished by ACOs, and to seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for the purposes of assessing the quality of care.

CMS is adding, as proposed, one new measure to the Preventive Health domain, which would increase the current total number of measures from 33 to 34 measures – Statin Therapy for the Prevention and Treatment of Cardiovascular Disease. Data collection for the new measure would occur through the CMS web interface.

Table 45 lists the Shared Savings Program quality measure set, including the one measure being proposed, that would be used to assess ACO quality starting in 2016.

## Measures for Use in Establishing Quality Performance Standards that ACOS Must Meet for Shared Savings

Domain	ACO Measure #	Measure Title	New Measure	NQF #/ Measure Steward	Method of Data Submission	Pay for Performance Phase-in R -Reporting P-Performance		
<b>AIM: Better Care for Individuals</b>								
Patient/ Caregiver Experience	ACO - 1	CAHPS: Getting Timely Care, Appointments, and Information		NQF #0005, AHRQ	Survey	R	P	P
	ACO - 2	CAHPS: How Well Your Doctors Communicate		NQF #0005 AHRQ	Survey	R	P	P
	ACO - 3	CAHPS: Patients' Rating of Doctor		NQF #0005 AHRQ	Survey	R	P	P
	ACO - 4	CAHPS: Access to Specialists		NQF #N/A CMS/AHRQ	Survey	R	P	P
	ACO - 5	CAHPS: Health Promotion and Education		NQF #N/A CMS/AHRQ	Survey	R	P	P
	ACO - 6	CAHPS: Shared Decision Making		NQF #N/A CMS/AHRQ	Survey	R	P	P
	ACO - 7	CAHPS: Health Status/Functional Status		NQF #N/A CMS/AHRQ	Survey	R	R	R
	ACO - 34	CAHPS: Stewardship of Patient Resources		NQF #N/A CMS/AHRQ	Survey	R	P	P
Care Coordination Safety	ACO - 8	Risk-Standardized, All Condition Readmission		Adapted NQF #1789 CMS	Claims	R	R	P
	ACO - 35	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)		Adapted NQF #2510 CMS	Claims	R	R	P
	ACO - 36	All-Cause Unplanned Admissions for Patients with Diabetes		NQF#TBD CMS	Claims	R	R	P
	ACO - 37	All-Cause Unplanned Admissions for Patients with Heart Failure		NQF#TBD CMS	Claims	R	R	P
	ACO - 38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions		NQF#TBD CMS	Claims	R	R	P
	ACO - 9	Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (AHRQ Prevention Quality Indicator (PQI) #5)		Adapted NQF #0275 AHRQ	Claims	R	P	P
	ACO - 10	Ambulatory Sensitive Conditions Admissions: Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8 )		Adapted NQF #0277 AHRQ	Claims	R	P	P
	ACO - 11	Percent of PCPs who Successfully Meet Meaningful Use Requirements		NQF #N/A CMS	EHR Incentive Program Reporting	R	P	P
	ACO -39	Documentation of Current Medications in the Medical Record		NQF #0419 CMS	CMS Web Interface	R	P	P
	ACO - 13	Falls: Screening for Future Fall Risk		NQF #0101 NCQA	CMS Web Interface	R	P	P

## Measures for Use in Establishing Quality Performance Standards that ACOS Must Meet for Shared Savings

Domain	ACO Measure #	Measure Title	New Measure	NQF #/ Measure Steward	Method of Data Submission	Pay for Performance Phase-in R -Reporting P-Performance		
<b>AIM: Better Health for Populations</b>								
Preventive Health	ACO - 14	Preventive Care and Screening: Influenza Immunization		NQF #0041 AMA-PCPI	CMS Web Interface	R	P	P
	ACO - 15	Pneumonia Vaccination Status for Older Adults		NQF #0043 NCQA	CMS Web Interface	R	P	P
	ACO - 16	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up		NQF #0421 CMS	CMS Web Interface	R	P	P
	ACO - 17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention		NQF #0028 AMA-PCPI	CMS Web Interface	R	P	P
	ACO - 18	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan		NQF #0418 CMS	CMS Web Interface	R	P	P
	ACO - 19	Colorectal Cancer Screening		NQF #0034 NCQA	CMS Web Interface	R	R	P
	ACO - 20	Breast Cancer Screening		NQF #NA NCQA	CMS Web Interface	R	R	P
	ACO - 21	Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented		CMS	CMS Web Interface	R	R	P
	ACO - 42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	X	NQF #TBD MUC ID: X3729 CMS	CMS Web Interface	R	R	P
Clinical Care for At Risk Population - Depression	ACO - 40	Depression Remission at Twelve Months		NQF #0710 MNCM	CMS Web Interface	R	R	R
Clinical Care for At Risk Population - Diabetes	ACO - 27	Diabetes Composite (All or Nothing Scoring):  ACO - 27: Diabetes Mellitus: Hemoglobin A1c Poor Control		NQF #0059 NCQA (individual component)	CMS Web Interface	R	P	P
	ACO - 41	ACO - 41: Diabetes: Eye Exam		NQF #0055 NCQA (individual component)	CMS Web Interface	R	P	P
Clinical Care for At Risk Population - Hypertension	ACO - 28	Hypertension (HTN): Controlling High Blood Pressure		NQF #0018 NCQA	CMS Web Interface	R	P	P
Clinical Care for At Risk Population - Ischemic Vascular Disease	ACO - 30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic		NQF #0068 NCQA	CMS Web Interface	R	P	P

## Measures for Use in Establishing Quality Performance Standards that ACOS Must Meet for Shared Savings

Domain	ACO Measure #	Measure Title	New Measure	NQF #/ Measure Steward	Method of Data Submission	Pay for Performance Phase-in		
						R - Reporting	R - Performance	P
Clinical Care for At Risk Population -Heart Failure	ACO - 31	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)		NQF #0083 AMA-PCPI	CMS Web Interface	R	R	P
Clinical Care for At Risk Population - Coronary Artery Disease	ACO - 33	Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – for patients with CAD and Diabetes or Left Ventricular Systolic Dysfunction (LVEF<40%)		NQF #0066 ACA	CMS Web Interface	R	R	P

### M. Value-Based Payment Modifier and Physician Feedback Program

Section 1848(p) of the Act requires that CMS establish a value-based payment modifier and apply it to specific physicians and groups of physicians the Secretary determines appropriate starting Jan. 1, 2015, and to all physicians and groups of physicians by Jan. 1, 2017.

Under the Value Modifier Program, performance on quality and cost measures can translate into increased payment for physicians and other EPs who provide high-quality, efficient care and decrease payments for low performing physicians another EPs who underperform. The value modifier is set to expire at the end of CY 2018 as a new comprehensive program, required by MACRA, (MIPs) begins in calendar year 2019 The final policies established in this rule are intended to help provide a smooth transition on the value modifier to MIPS.

CMS is finalizing the following provisions.

- To apply the Value Modifier to non-physician EPs who are Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists (and not to other non-physician EP types) in groups and

to PAs, NPs, CNSs, and CRNAs who are solo practitioners, in the CY 2018 payment adjustment period;

- To apply the quality-tiering methodology to all groups and solo practitioners that meet the criteria to avoid the downward adjustment under the PQRS. Groups and solo practitioners would be subject to upward, neutral, or downward adjustments derived under the quality-tiering methodology, with the exception that PAs, NPs, CNSs, and CRNAs in groups consisting of non-physician EPs and PAs, NPs, CNSs, and CRNAs who are solo practitioners will be held harmless from downward adjustments under the quality-tiering methodology in CY 2018;
- To continue to set the maximum upward adjustment under the quality-tiering methodology for the CY 2018 Value Modifier at: +4.0 times an adjustment factor (to be determined after the conclusion of the performance period), for groups of physicians with ten or more EPs; +2.0 times an adjustment factor, for groups of physicians with between two to nine EPs and physician solo practitioners; and +2.0 times an adjustment factor for groups that consist of non-physician EPs and solo practitioners who are PAs, NPs, CNSs, and CRNAs; and

- To set the amount of payment at risk under the CY 2018 Value Modifier to -4.0 percent for groups of physicians with ten or more EPs, -2.0 percent for groups of physicians with between two to nine EPs and physician solo practitioners, and -2.0 percent for groups that consist of non-physician EPs and solo practitioners who are PAs, NPs, CNSs, and CRNAs.
- To waive application of the Value Modifier for groups and solo practitioners, as identified by their Taxpayer Identification Number, if at least one EP who billed for PFS items and services under the TIN during the applicable performance period for the Value Modifier participated in the Pioneer ACO Model, Comprehensive Primary Care Initiative, or other similar Innovation Center model (such as Comprehensive ESRD Care Initiative, Oncology Care Model, and the Next Generation ACO Model) during the performance period, beginning with the CY 2017 payment adjustment period;
- To use CY 2016 as the performance period for the CY 2018 Value Modifier and continue to apply the CY 2018 Value Modifier based on participation in the PQRS by groups and solo practitioners;
- Beginning with the CY 2017 payment adjustment period, we are increasing the minimum episode size for the Medicare Spending per Beneficiary measure to be included in the Value Modifier to 125 episodes for all groups and solo practitioners. Also, beginning with the CY 2017 payment adjustment period, for solo practitioners and groups with two to nine EPs, we are finalizing that the All-Cause Hospital Readmissions measure will not be used in the quality composite calculation for the Value Modifier. These changes are being made to be consistent with our

policy to only use measures that have moderate to high reliability.

- To not apply the automatic downward adjustment applicable to TINs that do not meet the criteria to avoid the downward adjustment under PQRS, when PQRS determines on informal review that at least 50 percent of the TIN's EPs meet the criteria to avoid the downward PQRS payment adjustment. Also, we note that if the group was initially determined to have not met the criteria to avoid the PQRS downward payment adjustments and consequently was initially subject to the automatic downward adjustment under the Value Modifier, then we do not expect to have data for calculating their quality composite, in which case they would be classified as "average quality."

## **N. Physician Self-Referral Updates**

Section 1877 of the Act, also known as the physician self-referral law: (1) prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership or compensation), unless an exception applies; and (2) prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third party payer) for those referred services.

The rule expands the regulations to establish two new exceptions and clarifies certain regulatory terminology and requirements.

### **New Exceptions:**

The rule establishes a new exception to permit payment by hospitals, federally qualified health centers and rural health clinics to physicians for the purpose of compensating non-physician practitioners under certain conditions.

It also establishes a new exception to permit timeshare arrangements for the use of office space, equipment, personnel, items, supplies, and other services. CMS believes these new exceptions will enhance access to care across all areas and will be particularly helpful in rural and underserved areas.

### **Updating Physician-Owned Hospital Requirements:**

The ACA established new restrictions on physician-owned hospitals, including setting a baseline physician ownership percentage that they cannot exceed and requiring them to state on their websites and in their advertising that physicians own them. CMS updated the regulations to clarify that a broad range of actions comply with the website and advertising requirements. CMS also finalized conforming changes that better align the regulations to the statute so that the baseline and future calculations of a hospital's physician ownership percentage includes all physicians rather than only those physicians who refer to the hospital. The physician ownership calculation change takes effect on Jan. 1, 2017.

### **Reducing Burden Through Clarifying Terminology and Providing Policy Guidance:**

The self-referral disclosure protocol allows CMS to settle overpayments resulting from physician self-referral law violations. Review of self-disclosures indicates that clarifying terminology and providing policy guidance could reduce perceived or actual noncompliance without risk of abuse. CMS is making the following updates.

- Clarifying that compensation paid to a physician organization cannot take into account the referrals of any physician in the physician organization, not just a physician who stands in the shoes of the physician organization, and that employees and independent

contractors need not sign arrangements between the physician organization and a DHS entity;

- Clarifying that the writing required in many of the exceptions to the physician self-referral law's referral and billing prohibitions can be a collection of documents (as opposed to a single formal contract) and making the terminology that describes types of arrangements consistent throughout the regulations;
- Clarifying that the term of a lease or personal service arrangement need not be in writing if the arrangement lasts at least one year and is otherwise compliant;
- Allowing expired leasing and personal services arrangements to continue indefinitely on the same terms if otherwise compliant;
- Allowing a 90-day grace period to obtain missing signatures without regard to whether the failure to obtain the signature was inadvertent;
- Clarifying that designated health services entities can give to physicians items used solely for one or more of the purposes identified in the statute;
- Clarifying that a financial relationship does not exist when a physician provides services to hospital patients in the hospital if both the hospital and the physician bill independently for their services;
- Updating obsolete language in the exception for ownership in publicly traded entities to allow over-the-counter transactions and removing unnecessary language from the definition of a locum tenens physician;
- Clarifying the geographic service area for the FQHCs and RHCs using the physician recruitment exception; and
- Correcting a drafting error so that the retention exception indicates that retention payments based on physician

certification may be no more than 25 percent of the physician's current annual salary averaged over 24 months (as opposed to no more than 24 months).

*Analysis provided for MHA  
by Larry Goldberg,  
Goldberg Consulting*

### **O. Private Contracting/Opt-out**

Section 106(a) of MACRA amends section 1802(b)(3) of the Act to require that opt-out affidavits filed on or after June 16, 2015, automatically renew every 2 years. Therefore, physicians and practitioners that file opt-out affidavits on or after June 16, 2015 will no longer be required to file renewal affidavits in order to continue their opt-out status.

### **FINAL OBSERVATION**

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As noted here and in other PPS material, overall documentation continues to grow. In this rule, CMS tells the reader it "appreciates" commenter's support some 228 times. Maybe it's time for CMS to revise its rulemaking format. Yes, CMS needs to address and reflect comments made to its proposals, but needs to do so in a simpler and shorter mechanism.

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