

2014 Proposed Medicare Physician Fee Schedule Analysis Exclusively for MGMA-ACMPE Members

The Centers for Medicare & Medicaid Services (CMS) published the proposed [2014 Medicare fee schedule for physician services](#) July 19, 2013. The regulation discusses policies that affect Part B payments for physician services furnished on or after Jan. 1, 2014. CMS will accept public comments on the rule until Sept. 6, 2013, and intends to issue a final rule by Nov. 1. MGMA will submit formal comments and share them with members through the MGMA *Washington Connexion* newsletter.

Also, see the updated [MGMA fee schedule analysis tool](#) that allows you to compare next year's proposed fee schedule to this year's final fee schedule. Upload CPT codes for the providers in your practice, and the tool will calculate the changes in work and total RVU values.

Practice expense (PE) RVUs

CMS proposes to limit the payment for certain services where the PFS nonfacility payment is higher than the total payment to furnish the same service in a facility setting (either a hospital outpatient department or an ambulatory surgery center (ASC)). In the proposed rule, CMS explains that this approach would provide a way for CMS to set upper Medicare payment limits for office-based procedures based on relatively more reliable cost information for procedures furnished in a facility setting where the cost structure is expected to be higher than the office setting. CMS cites unreliable direct PE input data used for the PFS as a rationale for the proposed change, stating that the outpatient prospective payment system (OPPS) payment rates are based on auditable hospital data that are updated annually. CMS believes that the more accurate OPPS data should be used in situations where the nonfacility PFS payment rates for procedures exceed those for the same procedure when furnished in a facility. CMS proposes to use this approach beginning in 2014 and estimates that approximately 200 codes would have their PE RVUs reduced to the OPPS/ASC rate. These codes can be viewed [here](#).

Under this proposal, CMS would exempt certain services from this policy, including:

- Services without separate OPPS payment rates
- Codes subject to the Deficit Reduction Act imaging cap
- Codes with low volume in the OPPS or ASC
- Codes with ASC rates based on PFS payment rates
- Codes paid in the facility at nonfacility PFS rates
- Codes with PE RVUs developed outside the PE methodology

Imaging

The equipment utilization rate assumption is used to calculate the practice expense RVUs in the technical component payment, with a higher utilization assumption resulting in a lower payment. CMS currently uses an equipment utilization rate assumption of 50 percent for most equipment, with the exception of expensive diagnostic imaging equipment priced at more than \$1 million (for example, computed tomography (CT) and magnetic resonance imaging (MRI) scanners). For this equipment, CMS uses an equipment utilization rate assumption of 75 percent. Beginning in 2014, CMS will use a 90 percent equipment utilization rate assumption for expensive diagnostic imaging equipment as required by the America Taxpayer Relief Act of 2012. Codes subject to this new policy can be viewed in [Table 3](#).

Collecting data on services furnished in off-campus hospital provider-based departments

CMS is considering collecting data on services furnished in off-campus hospital provider-based departments (provider-based departments) in order to better understand the trend of hospital acquisition of physician offices and treatment of those locations as provider-based departments. CMS is considering collecting information on the frequency, type and payment for such services. CMS requests comments on a few different proposed methods to collect this information, including:

- A claims-based approach that would create a new place of service code for provider-based departments as part of item 24B of the CMS-1500 claim form
- A claims-based approach that would create a HCPCS modifier that would be reported for services furnished in a provider-based department on the CMS-1500 claim form for physician services and the UB-04 (CMS form 1450) for hospital outpatient claims
- A requirement that hospitals break out the costs and charges for their provider-based departments as outpatient service cost centers on the Medicare hospital cost report form 2552-10

Other proposed PE RVU changes

CMS proposes a few more changes to PE RVUs, such as:

- Making minor adjustments to the nurse and equipment time for about 20 nonfacility codes for which moderate sedation is inherent in the procedure. These codes appear in [Table 8](#).
- Decreasing the minutes of clinical labor to 30 minutes or fewer in the pre-service period in the facility setting for 48 codes with 000 day global periods. This proposal to amend the pre-service clinical labor minutes for the codes listed in [Table 9](#) is consistent with a recent American Medical Association's (AMA) Relative Value Scale Update Committee (RUC) recommendation regarding appropriate pre-service clinical labor minutes for these codes.

- Modifying the existing equipment inputs based on the typical items used in ultrasound rooms when furnishing ultrasound services. The codes that would be impacted by this proposed change to direct PE inputs are in [Table 10](#).

Potentially misvalued codes

CMS is required by statute to periodically review potentially misvalued codes and make appropriate adjustments to the relative values of those services. It also must develop a formal process to validate RVUs under the Medicare PFS. The agency has entered into two contracts with outside entities (the RAND Corporation and the Urban Institute) to develop validation models for RVUs.

CMS finalized a process for the public to nominate potentially misvalued codes but did not receive any nominations this year. It solicited input from Medicare contractor medical directors (CMDs) and, in consultation with the CMDs, identified 14 codes as potentially misvalued. ([Table 11](#)) It also identified seven additional potentially misvalued codes that use ultrasound guidance. ([Table 12](#)) With respect to the valuation of global surgical packages and measuring post-operative work, CMS received a comment from the AMA RUC noting that hospital and discharge day management services included in the global period for many surgical procedures may have been inadvertently removed from the time file for several codes. Thus, CMS is proposing to replace missing post-operative hospital E&M visit information and time for 117 codes. ([Table 13](#))

Finally, CMS reaffirmed its longstanding aim to implement multiple procedure payment reduction (MPPR) policies to reflect reduced resources involved with services that are frequently furnished together. CMS is not proposing any new MPPR policies at this time but will continue to look at opportunities to expand this effort. Any specific proposals will be included in a future rulemaking and will be subject to public comment.

Malpractice RVUs

The Social Security Act requires malpractice RVUs to be reviewed and, if necessary, adjusted at least every five years. The next review and update is scheduled to occur in 2015. For new codes that are effective before the next five-year review, CMS establishes malpractice RVUs either by a direct crosswalk to a similar "source" code or a modified crosswalk to account for differences in work RVUs between the new code and the source code. For 2014, CMS will continue its current approach for determining malpractice RVUs for new/revised codes and will publish a list of those codes and the malpractice crosswalks used for determining their malpractice RVUs in the final rule. The RVUs will be implemented in 2014 and will also be subject to public comment. They will be finalized in the 2015 final rule.

Medicare economic index (MEI)

The MEI represents the statutory price component of the Sustainable Growth Rate (SGR) methodology used to update the PFS. The MEI measures price changes in the inputs (goods and services) required to operate a self-employed physician practice in the United States. These inputs are aggregated into two broad categories – the physician’s time and practice expenses.

As finalized in the 2011 PFS final rule, CMS convened an MEI Technical Advisory Panel ([MEI TAP](#)) to review all aspects of the MEI, including inputs, input weight, price-measurement proxies and productivity adjustment. The MEI TAP was tasked with assessing the relevance and accuracy of these inputs for current physician practices. For 2014, CMS proposes to revise the MEI categories, cost shares and price proxies based on 10 of the 13 recommendations made by the MEI TAP. CMS will continue to use data from 2006 to estimate cost weights since these are the most recent, relevant and complete data available, according to the agency.

[Table 14](#) lists the cost categories and weights that make up the proposed revised MEI compared with the current MEI cost categories. The revisions will have varying effects on different codes and specialties. [Table 72](#) shows the estimated impact of selected policy proposals, including the revised MEI, on total allowed charges by specialty.

Geographic practice cost indices (GPCIs)

CMS is required by law to develop separate GPCIs to measure resource cost differences among geographic localities compared with the national average for the physician work, PE and malpractice components of the PFS. CMS must update the GPCIs every three years. The 2014 proposed GPCI values reflect CMS’s seventh review of the GPCIs.

According to statute, if more than one year has elapsed since the previous GPCI adjustment, the next GPCI adjustment must be phased in over two years. Therefore, CMS is proposing to phase in one-half of the latest GPCI adjustment in 2014.

For the past several GPCI updates, CMS has not been able to collect malpractice expense premium data from insurer rate filings for the Puerto Rico locality. Based on recently acquired malpractice expense insurance premium data, CMS proposes a 17 percent increase for malpractice GPCIs for the Puerto Rico payment locality, which would be effective in 2015.

CMS has historically updated GPCI cost share weights (physician work, PE and malpractice) to make them consistent with the most recent update to the MEI. Therefore, CMS proposes to make adjustments to the GPCI cost share weights such that the GPCI mix will match the proposed 2014 MEI mix. The proposed GPCI cost share weights for 2014 are displayed in [Table 22](#).

The American Taxpayer Relief Act (ATRA) extended the 1.0 work GPCI floor until Dec. 31, 2013. Without further Congressional action, the 1.0 work GPCI floor is set to expire Jan. 1,

2014. Therefore, CMS's proposed GPCIs do not reflect the 1.0 work GPCI floor. The only exception to this is the permanent 1.5 work GPCI floor for Alaska. The Patient Protection and Affordable Care Act (ACA) created a 1.0 PE GPCI floor for "frontier" states beginning in 2011. Frontier states include Montana, North Dakota, Nevada, South Dakota and Wyoming, and the PE GPCI floor for these states will remain at 1.0 for 2014.

The proposed 2014 and 2015 GPCIs are displayed in Addendum E of the CMS [website](#). Additional information on the 2014 GPCI update may be found at CMS's contractor's *Draft Report on the CY 2014 Update on Geographic Practice Cost Index for the Medicare Physician Fee Schedule*.

Telehealth services

For 2013, CMS finalized two new post-discharge transitional care management (TCM) services for Medicare (99495 and 99496). TCM services focus on care coordination in the 30 days following a Medicare beneficiary's discharge from an inpatient hospital, skilled nursing facility, community mental health center or following outpatient hospital observation services or a partial hospitalization. TCM comprises one face-to-face visit during specified timeframes in combination with non-face-to-face services that may be performed by the physician or another qualified healthcare professional and/or licensed clinical staff under his or her direction. The agency believes that the interactions between the furnishing practitioner and the beneficiary during the required TCM face-to-face visit are sufficiently similar to services currently on the list of Medicare telehealth services. As a result, CMS proposes to add the TCM services to the 2014 approved telehealth services list.

CMS proposes to make technical revisions regarding telehealth originating sites in order to define rural health professional shortage areas (HPSAs) as those located in rural census tracts as determined by the Office of Rural Health Policy. The agency believes that such a change would allow for the appropriate inclusion of additional HPSAs as areas for originating sites and would expand access to healthcare services for Medicare beneficiaries located in rural areas. CMS also proposes to change its policy so that geographic eligibility for an originating site would be established and maintained on an annual basis, consistent with other telehealth payment policies.

Therapy caps

As required by statute, CMS applies annual, per beneficiary limitations or "therapy caps" on expenses for outpatient therapy services under Medicare Part B. There is one therapy cap for physical therapy (PT) and speech-language pathology (SLP) services combined and a separate therapy cap for outpatient occupational therapy (OT) services. Congress has repeatedly created an exceptions process to the therapy caps and most recently did so for 2013. Without Congressional action, the therapy cap exceptions process will expire Dec. 31, 2013. The 2013 therapy cap amount is \$1,900, and the amount for 2014 will be announced in the 2014 final PFS.

As a result of the Middle Class Tax Relief and Job Creation Act (MCTRJCA) of 2012, CMS broadened the application of the therapy caps in the last quarter of 2012 to include outpatient therapy services furnished by hospitals. MCTRJCA also required a manual medical review process for therapy claims when a beneficiary's incurred expenses exceed \$3,700 in a given year. As with the therapy caps, there are two separate thresholds of \$3,700, one for PT and SLP combined and another threshold for OT. Congress later extended both of these provisions through 2013, and without further Congressional action, they will expire on Dec. 31, 2013. In the proposed 2014 PFS, CMS would also include therapy services furnished by critical access hospitals as services that count toward the therapy caps beginning Jan. 1, 2014. Manual medical reviews would only be extended if Congress acts to continue them.

Requirements for billing "incident to" services

CMS proposes to modify the requirements for auxiliary personnel providing services "incident to" the services of a physician or other practitioner. In general, the current regulations require that "incident to" services be:

- 1) Furnished in a non-institutional setting to non-institutional patients
- 2) An integral, though incidental, part of the service of a physician or other practitioner in the course of diagnosis or treatment of an injury or illness
- 3) Furnished under direct supervision of a physician or other practitioner eligible to bill and directly receive Medicare payment
- 4) Furnished by the physician, practitioner with an "incident to" benefit or auxiliary personnel. "Incident to" services are paid at the applicable rate of the physician or practitioner billing for the service.

The current "incident to" regulations do not specifically require that personnel performing "incident to" services meet state law requirements for performing such services. CMS has been made aware of several instances in which services billed as "incident to" services were performed by individuals who did not qualify to perform those services under their applicable state law. CMS proposes to amend the "incident to" regulations to directly require that personnel performing "incident to" services meet any applicable state law requirements to provide the services, including licensure. CMS believes this change will provide a clear basis to deny claims and help ensure it has recourse to recover Medicare dollars when services are not furnished in compliance with state laws. The proposed changes are consistent with a 2009 recommendation made by the Department of Health and Human Services Office of Inspector General with respect to "incident to" services.

Complex chronic care management services (CCCMS)

CMS is developing and implementing a number of initiatives to enhance care coordination for Medicare beneficiaries. Currently, payment for non-face-to-face care management services is

bundled into the payment for face-to-face E&M visits. However, CMS acknowledges that E&M codes do not reflect all the services and resources required to furnish comprehensive, coordinated care management for certain Medicare beneficiaries, especially those with multiple chronic conditions. In order to address this, CMS proposes to establish a separate payment beginning in 2015 for CCCMS furnished to patients with multiple complex chronic conditions. Under the proposal, complex chronic conditions would be those that are expected to last at least 12 months or until the death of the patient and that place the patient at significant risk of death, acute exacerbation/decompensation or functional decline.

CMS proposes to create two new separately payable G-codes for CCCMS:

- GXXX1, initial services; one or more hours; initial 90 days
- GXXX2, subsequent services; one or more hours; subsequent 90 days

While the agency proposes a number of criteria that would be required as part of these services, CMS is not proposing any RVUs for these services at this time. CMS proposes that the scope of these services would include things such as:

- 24 hour a day, 7 day a week access to address a patient's complex chronic care needs
- Systematic assessment of a patient's medical, functional and psychosocial needs
- Medication reconciliation with review of adherence and potential interactions as well as oversight of patient self-management of medications
- Development of a patient-centered plan of care document including things such as a problem list, planned interventions, medication management and community/social services ordered
- Management of healthcare transitions, including referrals to other clinicians and visits following a trip to an emergency room or discharge from a hospital
- Opportunities for a patient to communicate with the provider via phone as well as through the use of secure messaging, Internet or other non face-to-face consultation methods

Under the proposal, beneficiaries would have to consent to receive CCCMS and only one provider would be able to bill for each CCCMS G-code for the same beneficiary in a given year. Additionally, CMS proposes that a healthcare provider would need to document in the medical record that the beneficiary agrees to accept these services. The patient's acceptance would need to be reaffirmed and documented every 12 months. CMS also proposes that a beneficiary must have received a Medicare Annual Wellness Visit in the past 12 months for a practitioner to be able to bill separately for CCCMS. CMS expects that many CCCMSs would be furnished incident to a physician's services. The agency proposes that time spent by a clinical staff person furnishing aspects of CCCMS outside the practice's normal business hours during which there is no direct physician supervision would count towards the one hour requirement to bill each G-

code, even though the services do not meet the direct supervision requirement for “incident to” services.

In addition to the required CCCMS components, CMS also proposes that providers would have to meet certain criteria to be eligible to furnish these services. For instance, a practice would have to be using an EHR certified for the meaningful use incentive program and practitioners would need to be able to access this system 24 hours a day, 7 days a week. The practice would have to employ one or more advanced practice registered nurses or physician assistants whose written job descriptions indicate that their duties include and are appropriately scaled to meet the needs for beneficiaries receiving CCCMS provided by the practice. Additionally, CMS proposes almost a dozen other required protocols that a practice would have to document in writing to be eligible to furnish CCCMS. CMS seeks comments on how a practice could demonstrate that it meets required standards and whether a medical home designation would be an appropriate means to do this.

Ultrasound screening for abdominal aortic aneurysms

Medicare Part B covers ultrasound screening for abdominal aortic aneurysms (AAA) when a beneficiary receives a referral for the screening during the initial preventive physical examination (IPPE) and has not previously received an AAA screening under the Medicare program. The IPPE must occur within one year of the effective date of the beneficiary's first Part B coverage period. This time limitation reduces the number of Medicare beneficiaries who are eligible to receive the screening, according to CMS. Based on a recommendation from the United States Preventive Services Task Force, CMS proposes to expand access to this preventive service by removing the requirement that a beneficiary receive a referral for AAA screening as part of his or her IPPE. The effect of this proposed change would be to eliminate the one year time limitation.

Mechanism to review clinical laboratory test payments

CMS proposes a new process to review payments made for clinical laboratory tests. Currently, CMS only reviews and reconsiders the Medicare Part B payment for clinical diagnostic laboratory tests during the year after the payment is established. After the reconsideration process, payment is not significantly modified regardless of shifts in the actual costs incurred to perform the test. Payments are subject to smaller adjustments to reflect change in the Consumer Price Index for all Urban Consumers and a productivity adjustment, both of which are used to annually update all clinical laboratory fee schedule (CLFS) amounts. CMS notes that other services paid through Medicare fee schedules and prospective payment systems are evaluated each year to reflect changes to things, such as price inputs or to account for new services. These changes are all required to be budget neutral, meaning that there are cost shifts within the payment system but the overall system, such as the Medicare PFS, does not change by more than \$20 million.

CMS proposes to establish a mechanism to review payments for lab tests to account for cost changes resulting from things, such as technological advances, site-of-service shifts and changes in laboratory personnel or supplies necessary to conduct a test. Under the proposal, beginning in 2015 and for each subsequent year, CMS would review certain lab codes to determine whether an increase or reduction in payment would be warranted. CMS would identify the test code and a proposed payment change in the proposed PFS and would respond to public comments and make any changes in the final PFS. CMS proposes to review all 1,250 codes on the CLFS, which the agency estimates would take at least five years. After the initial review, CMS would review codes approximately every five years and would allow public nomination to review codes that have not been reviewed in the previous five years.

Liability for overpayments

Current regulations allow CMS to waive recovery of overpayments in certain situations. When an overpayment is discovered subsequent to the third year after CMS paid it, a provider is deemed to be without fault, absent any evidence to the contrary. For a provider who is without fault, the regulations deem recovery of those overpayments discovered subsequent to the third year to be “against equity and good conscience.”

The American Taxpayer Relief Act of 2012 amended the statute on which these provisions are based, changing the timeframe from the third year to the fifth year. Thus, CMS proposes to amend its regulations to conform to the new statute, deeming a provider to be without fault and recovery of overpayments to be against equity and good conscience for overpayments discovered subsequent to the fifth year it is paid. The effect of this change would be to allow CMS to recover overpayments for which the provider is without fault for two additional years. CMS clarified that these proposed changes do not affect CMS’s claims reopening regulations.

Physician Compare website

The [Physician Compare website](#) contains information about healthcare providers enrolled in Medicare. The website is mandated by ACA, and CMS must add more information in the coming years. Physician Compare contains basic information such as name, education, physician specialty, Medicare participation status, practice location and participation status in PQRS or the Medicare e-prescribing incentive program. CMS recently added information to Physician Compare, including participation in the Meaningful Use EHR program, secondary specialties, hospital affiliations, languages spoken and board certification information from the American Board of Medical Specialties. For group practices, CMS added information on quality programs, including satisfactory reporting in Group Practice Reporting Options (GPRO) under the PQRS or e-prescribing programs.

CMS is required to report performance information on quality measures and, in 2014, will begin a phased approach to doing so. As part of this effort, in the final 2013 Medicare PFS, the agency

finalized that beginning in 2014 it will report a limited set of performance data on 2012 and 2013 PQRS GPRO web interface measures, such as measures related to diabetes and coronary artery disease, and quality measure performance data from accountable care organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP). Additionally, CMS will report patient experience measure data from the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) for group practices of 100 or more eligible professionals (EPs) reporting data in 2013 under PQRS GPRO and for ACOs participating in the MSSP.

CMS proposes to expand the quality measures posted on Physician Compare to include performance on all measures collected through the GPRO web interface for groups of all sizes participating in 2014 in the PQRS GPRO and for ACOs in the MSSP. These data would include measure performance rates for measures meeting the minimum sample size of 20 patients. If finalized, CMS would provide a 30-day preview period so that group practices and ACOs could view their data as it will appear on Physician Compare before it is publicly reported. CMS does not propose details for the 30-day preview but states that it will specify this process, including a timeline and instructions, at a later time. The agency also proposes to publicly report 2014 CG-CAHPS data for any group practice (regardless of size) that voluntarily chooses to report CG-CAHPS and has this information collected by a certified CAHPS vendor.

CMS proposes to report, no earlier than 2015, performance data on a wide range of measures for groups participating via registries and EHRs in 2014 PQRS GPRO. CMS also proposes to publicly report PQRS measure data for individual EPs participating in 2014 PQRS using the claims, EHR or registry reporting options. This would be the first time Physician Compare would include measure performance data on individual EPs, and the agency proposes only reporting certain individual measures and doing so as early as 2015. Additionally, CMS proposes to report, no earlier than 2015, performance rates on measures in the PQRS Cardiovascular Prevention measures group at the individual level for PQRS data collected in 2014.

Physician Quality Reporting System (PQRS)

EPs who successfully report on quality measures in PQRS are eligible for a 0.5 percent incentive in 2014, the final year CMS will offer an incentive payment in this program. As previously established in the 2013 Medicare PFS, EPs who do not satisfactorily report PQRS quality data will receive a 1.5 percent reduction under Medicare for 2015. In 2016 and beyond, EPs who do not satisfactorily report PQRS quality data in 2014 will receive a -2 percent penalty under Medicare.

Proposed changes to reporting criteria: earning a 2014 PQRS incentive

CMS proposes the following changes in criteria for individual EPs reporting individual measures to earn the 2014 incentive. Note that CMS does not propose to modify criteria for satisfactorily reporting individual quality measures via EHR that were established in the 2013 Medicare PFS:

Claims- Report at least nine measures covering at least three of the National Quality Strategy Domains. If nine measures do not apply, the EP would report on one to eight measures for at least 50 percent of the Medicare Part B fee-for-service (FFS) patients seen during the reporting period, to which the measure applies (12-month reporting period).

Registry- Report at least nine measures covering at least three of the National Quality Strategy 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 (12-month reporting period)

Qualified Clinical Data Registry- Report at least nine measures available for reporting under a "qualified clinical data registry," covering at least three of the National Quality Strategy Domains and report each measure for at least 50 percent of the EP's patients (not exclusive to Medicare FFS patients). Under this reporting option, the EP would be required to report at least one outcome measure. The EP would report measures directly to a qualified clinical data registry (not to CMS), and the registry would then report to CMS. This is a newly proposed reporting mechanism described further below (12-month reporting period).

Proposed addition of a "qualified clinical data registry" reporting method

As required under the "American Taxpayer Relief Act," CMS proposes a new "qualified clinical data registry" reporting method to allow EPs to be considered satisfactory reporters in PQRS through successful participation via a qualified clinical data registry (see above criteria). Under the proposal, CMS would define a qualified clinical data registry as a "CMS approved entity (such as a registry, certification board, collaborative, etc.) that collects medical and/or clinical data for the purposes of patients and disease tracking to foster improvement in the quality of care furnished to patients." Qualified clinical data registries would be required to submit a self nomination statement by Jan. 31 of the year in which the registry seeks to be qualified by CMS, and CMS intends to post the qualified clinical data registries list by fall of the reporting period.

CMS proposes the following changes in criteria for those in the Group Practice Reporting Option (GPRO) to earn the 2014 incentive:

Registry (available to groups with two or more EPs)- Report at least nine measures, covering at least three of the National Quality Strategy Domains and report each measure for at least 50 percent of the EPs Medicare Part B FFS patients seen during the reporting period, to which the measure applies (12-month reporting period).

Certified survey vendor + registry, EHR or web interface (available to groups with 25 or more EPs) - Report all CG-CAHPS survey measures via a certified survey vendor and report at least six measures covering at least 2 of the National Quality Strategy Domains using the registry, EHR, or web interface reporting mechanisms. This is a newly proposed reporting mechanism described further below (12 month reporting period)

Proposed addition of the GPRO “certified survey vendor” reporting mechanism

CMS proposes a new reporting option called the “certified survey vendor” reporting mechanism for groups participating in GPRO with 25 or more EPs. Groups using this option must report on 12 CG-CAHPS survey measures and report at least six additional measures covering at least two of the National Quality Strategy Domains using the registry, EHR or web interface reporting mechanisms. Under the proposal, groups would need to elect this option via the PQRS GPRO registration process. The 12 CG-CAHPS measures included in the proposal are:

- Getting timely care, appointments and information
- How well providers communicate
- Patient’s rating of provider
- Access to specialists
- Health promotion and education
- Shared decision making
- Health status/functional status
- Courteous and helpful office staff
- Care coordination
- Between visit communication
- Helping you to take medications as directed
- Stewardship of patient resources

CMS also proposes to change the GPRO self nomination deadline to Sept. 30 during the applicable reporting period, and to remove the option of GPRO web interface reporting for groups of 25-99 EPs, citing low participation.

Proposed changes to reporting criteria: Avoiding the 2016 PQRS penalty

CMS proposes that in order to avoid the 2016 PQRS penalty, EPs must meet the criteria detailed above for earning an incentive in 2014 (for individual EPs and GPRO).

Proposed changes to individual measures

CMS proposes to add 47 new measures to be made available in 2014 and beyond, and to retire 46 measures (see pgs. 43379-43447). CMS also proposes the removal of 19 measures' availability for reporting via the claims-based reporting method (see pgs. 43474-43476).

Proposed changes to measures groups

CMS proposes to modify the minimum number of measures that may be included in a PQRS measures group from four to six measures. The proposal would also add the following four new measures groups in 2014 and beyond: total knee replacement, general surgery, optimizing patient exposure to ionizing radiation and gastrointestinal surgery (see pgs. 43470-43474). CMS also proposes removing the option of individual EPs using measures groups reporting via the claims-based reporting mechanism for the 2014 incentive.

[Table 29](#) in the PFS contains a comprehensive list of the measures CMS proposes to include in the PQRS measure set for 2014 and beyond. [Tables 31-56](#) specify proposed measures groups for 2014 and beyond.

To view the current PQRS reporting criteria, download MGMA's [analysis of the 2013 Medicare physician fee schedule](#).

Meaningful use EHR incentive program

The PFS rule includes a number of proposed changes to the EHR incentive program (meaningful use). CMS attempts to better harmonize the requirements for its various clinical quality measurement (CQM) reporting programs.

Meeting the reporting program requirements

For purposes of meeting the CQM reporting component of meaningful use in 2014 and subsequent years, CMS proposes to allow EPs to submit CQM information using qualified clinical data registries. CMS proposes this new option beginning with the reporting periods in 2014 to minimize duplicative reporting and to further integrate quality reporting options under PQRS and meaningful use.

In addition to the criteria that are ultimately established for PQRS, CMS proposes the following additional criteria that an EP who reports CQMs for meaningful use using a qualified clinical data registry must satisfy:

- An EP must use Certified EHR Technology (CEHRT) required under meaningful use
- The CQMs reported must be included in the Stage 2 meaningful use final rule and use the same electronic specifications established for meaningful use
- An EP must report nine CQMs covering at least three National Quality Strategy Domains

- If an EP's CEHRT does not contain patient data for at least nine CQMs covering at least three domains, the EP must report the CQMs for which there is patient data and report the remaining CQMs as "zero denominators"
- An EP must have CEHRT that meets all of the criteria required for CQMs, including certification of the qualified clinical data registry for the functions it will fulfill (i.e., calculation, electronic submission)
- This qualified clinical data registry reporting option is only for EPs who are beyond their first year of demonstrating meaningful use

For purposes of avoiding a payment adjustment under Medicare, EPs who are in their first year of demonstrating meaningful use must satisfy their CQM reporting requirements by Oct. 1 in order to avoid a payment adjustment for the following year (for example, by Oct. 1, 2014, to avoid a payment adjustment in 2015). As proposed, EPs using the qualified clinical data registry reporting option would not be able to meet the deadline to avoid a payment adjustment because these qualified clinical data registries would be submitting data on CQMs by the last day of February following the 2014 PQRS incentive reporting periods, which would occur after Oct. 1, 2013.

EPs who are first-time meaningful users must report CQMs via attestation as established in the Stage 2 meaningful use final rule. The reporting periods established in the Stage 2 final rule would continue to apply to EPs who would choose to report CQMs under this proposed qualified clinical data registry reporting option for purposes of meaningful use. Note that may not satisfy requirements for other quality reporting programs that have established 12-month reporting periods, such as PQRS.

Proposed group reporting option – Comprehensive Primary Care Initiative (CPC)

The CPC Initiative is a multi-payer initiative fostering collaboration between public and private healthcare payers to strengthen primary care. Under this initiative, CMS will pay participating primary care practices a care management fee to support enhanced, coordinated services. CPC practice sites will submit a subset of the CQMs that were selected in the Stage 2 meaningful use final rule for EPs to report under the meaningful use program beginning in 2014.

CMS proposes to add a group reporting option for CQMs for meaningful use beginning in 2014 for EPs who are part of a CPC practice site that successfully submits at least nine electronically specified CQMs covering three National Quality Strategy Domains. CMS also proposes that each of the EPs in the CPC practice site would satisfy the CQM reporting component of meaningful use for the relevant reporting period if the CPC practice site successfully submits and meets the reporting requirements of the CPC Initiative. In addition, only those EPs who are beyond their first year of demonstrating meaningful use may use this proposed CPC group reporting option to avoid a payment adjustment.

Reporting of electronically-specified CQMs for the EHR incentive program

CMS proposes that EPs who report CQMs electronically under meaningful use must use the most recent version of the electronic specifications for the CQMs and have CEHRT that is tested and certified to the most recent version of the electronic specifications for the CQMs. EPs who do not wish to report CQMs electronically using the most recent version of the electronic specifications (for example, if their CEHRT has not been certified for that particular version) would be allowed to report CQM data to CMS by attestation for meaningful use.

Medicare Shared Savings Program (MSSP)

As established under previous regulations, ACO providers participating in the Medicare Shared Savings Program (MSSP) constitute a group practice for purposes of qualifying for a PQRS incentive under the MSSP.

MSSP ACOs: Avoiding the 2016 PQRS penalty

Under the proposed rule, ACOs on behalf of their ACO providers would be required to satisfactorily report the 22 ACO GPRO measures using the GPRO web interface established by CMS during the 2014 reporting period to avoid the 2016 PQRS penalty.

Establishing MSSP performance benchmarks

CMS proposes to use data submitted in 2013 by MSSP and Pioneer ACOs for the 2012 reporting period to set performance benchmarks for the 2014 reporting period. In the proposal, CMS also clarifies its intent to additionally combine data derived from national Medicare Advantage and national Medicare FFS to set performance benchmarks. CMS intends to publish these quality benchmarks through sub-regulatory guidance prior to the beginning of the 2014 reporting period.

Modifications to certain MSSP methodologies

CMS also proposes to develop a methodology aimed at spreading clustered performance on measures used in the MSSP. CMS data collected from GPRO participants in 2012 indicates that using actual data to calculate quality performance may result in some measures' performance rates being tightly clustered, meaning though there is little distinction in actual performance rates, a slight difference in performance on the measure may result in a significant difference in the number of quality points obtained for the purposes of the MSSP. CMS notes that "allowing clustered performance rates for a measure may result in payment differences that are not associated with clinically meaningful differences in patient care."

To address this issue, CMS proposes a standardized method for calculating benchmark rates when a measure's performance rates are tightly clustered. A "tightly clustered measure" would be defined as one in which the spread of performance rates between the 30th and 90th percentiles is less than 6.0 percentage points.

Lastly, CMS proposes to modify the scoring methodology for the “Patient/Caregiver Experience” domain to place a greater emphasis on the patient through greater prominence of patient-reported outcomes and experiences. CMS proposes to assign each of the seven survey module measures within the domain a maximum value of two points, making the domain worth a total of 14 points (an increase from the current four point total value). Under the proposal, each of the seven measure modules in the domain would be weighted equally; the Patient/Caregiver Experience domain would continue to comprise 25 percent of the ACO’s total quality performance score under this proposed change.

Value-based payment modifier (VBPM)

The ACA requires the Secretary of Health and Human Services to apply a VBPM, first to specific physicians and groups of physicians that the Secretary determines appropriate and ultimately to all Medicare Part B physicians by Jan. 1, 2017. The VBPM assesses both quality of care furnished and the cost of providing that care under the Medicare PFS. The VBPM must be budget neutral, meaning that upward payment adjustments for providers who furnish higher quality and lower cost care will be made based on the amount of downward adjustments applied to providers who furnish lower quality and higher cost care to Medicare beneficiaries.

CMS proposes to continue the implementation of the VBPM in 2016 by applying it to smaller groups of providers, and proposes changes to certain quality and cost components of the VBPM scoring criteria. To view the current VBPM criteria, download MGMA’s [analysis of the 2013 Medicare physician fee schedule](#).

Proposed application of the VBPM in 2016

For 2016, CMS proposes to apply the VBPM to groups of physicians with 10 or more EPs. The 2016 VBPM would be based on 2014 performance. Those who do not satisfactorily meet reporting criteria would be subject to a -2 percent penalty. Additionally, under the proposed rule, CMS would make quality-tiering mandatory for 2016. Quality-tiering is currently a voluntary option in the VBPM program and allows groups impacted by the VBPM an opportunity to earn upward payment adjustments for providing high quality, low cost care to Medicare beneficiaries as compared with a national average, while also putting the group at risk of receiving a downward adjustment for providing low quality, high cost care. Under the proposal, groups with 100 or more EPs would be subject to additional downside risk resulting from quality-tiering, while groups with 10 to 99 EPs would be subject to either neutral or positive incentives resulting from quality-tiering only.

Group size determination

CMS proposes to make the group size determination for VBPM purposes based on a query of Medicare Provider Enrollment Chain and Ownership System data within 10 days of the close of the PQRS GPRO self-nomination/registration period during the applicable performance year

(2014 for the application of the 2016 VBPM). CMS proposes no further changes to the methods of determining group size under the VBPM program. To view the current methodology, download MGMA's [analysis of the 2013 Medicare physician fee schedule](#).

VBPM adjustment based on PQRS participation

CMS proposes to establish two categories of physicians for the purposes of applying the VBPM in 2016.

Category 1: This would include groups of physicians using PQRS GPRO that meet the criteria for satisfactory reporting of PQRS quality measures for the purposes of avoiding the 2016 PQRS penalty.

Category 2: This would include groups of physicians subject to the VBPM that do not fall under Category 1.

CMS proposes that group practices in Category 1 would receive a positive, neutral or negative adjustment based on their quality-tiering score. EPs who fall in Category 2 would receive a -2 percent payment adjustment in 2016. Note that under this proposal, Category 1 would include groups of physicians that do not self-nominate in GPRO under PQRS, but at least 70 percent of the group's EPs meet the criteria for satisfactory PQRS reporting as individuals for the purposes of avoiding the 2016 PQRS penalty.

Quality-tiering amounts

For the 2016 VBPM quality-tiering adjustment, CMS proposes to apply a maximum -2 percent penalty under the quality-tiering methodology. Upward adjustments, or incentives earned under quality-tiering would be established by CMS based on the projected aggregate amount of downward payment adjustments determined under budget neutrality requirements.

2016 VBPM Amounts

Quality/cost	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Average quality	+1.0x*	+0.0%	-1.0%
Low quality	+0.0%	-1.0%	-2.0%

* Groups of physicians eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores.

Quality measures

Under the VBPM proposal, CMS would include all of the quality measures and reporting mechanisms available under PQRS for the 2014 reporting period (both individual and GPRO). For those groups of physicians subject to the VBPM in 2016 whose EPs participate in PQRS as individuals and are assessed under the 70 percent threshold criteria, CMS proposes to calculate the group's VBPM performance rate for each measure reported by at least one EP in the group by combining the weighted average of the performance rates of those EPs reporting the measure.

CMS proposes to classify a group as having average quality for quality-tiering purposes in circumstances where the agency is unable to receive quality performance data for EPs reporting through the new PQRS "qualified clinical data registry" reporting mechanism and all EPs in the group satisfactorily participate in a PQRS qualified clinical data registry in 2014. In those instances, CMS lacks available data to make a high or low quality determination.

Inclusion of the Medicare spending per beneficiary measure in the VBPM cost composite

CMS proposes to expand the cost composite of the VBPM from five to six measures to include an additional measure, the "Medicare Spending per Beneficiary" (MSPB) measure. By including this measure, CMS intends to recognize performance relating to post-acute care spending. The MSPB measure would be weighted equally with the existing "total per capita cost" measure for the "total per capita costs for all attributed beneficiaries" domain.

An MSPB episode would span from three days prior to an index admission at an applicable hospital through 30 days post discharge, with some exclusions. Costs for each episode would be risk adjusted for age and severity of illness, and the included payments standardized to account for geographic variation, using the same payment standardization methodology currently used for the "total per capita cost" measure included in the VBPM. Under the proposal, CMS would calculate the MSPB amount as the measure's performance rate.

CMS proposes to attribute an MSPB episode to a group of physicians, as identified by their Tax Identification Number (TIN), who are subject to the VBPM when any EP in the group submits a Part B Medicare claim under the group TIN for a service rendered during an inpatient hospitalization that is considered an index admission for the MSPB measure during the applicable performance period. This methodology would allow the same index admission and MSPB episode to be attributed to more than one group of physicians. CMS cites the goal of fostering shared accountability between hospitals and physicians for care provided to Medicare beneficiaries who are hospitalized as the reason for incorporating this measure. The MSPB measure has been submitted to the National Quality Forum for endorsement.

Specialty benchmarking inclusion in the VBPM

To more accurately account for a group practice's specialty composition so that quality-tiering produces fair peer group comparisons, CMS proposes changes to the calculation of the standardized score for each cost measure. CMS proposes to apply a "specialty adjustment" to

account for the specialty composition of the group prior to computing the standardized score for each cost measure. Under the proposal, CMS would adjust the standardized score methodology using three steps:

- 1) Create a specialty specific expected cost, based on the national average for each cost measure. For each specialty CMS would calculate the average cost of beneficiaries attributed to groups of physicians with that specialty, weighted by the number of EPs in each group.
- 2) Calculate the specialty adjusted expected cost for each group of physicians by weighting the national specialty-specific expected costs by the group's specialty composition of Part B payments.
- 3) Divide the total per capita cost by the specialty adjusted expected cost and multiply this ratio by the national average per capita cost to convert this ratio to a dollar amount to be used in the standardized score and to ultimately determine whether a group is classified as high, low or average cost.

Physician Feedback Program and Quality and Resource Use Reports (QRURs)

The Physician Feedback Program distributes QRURs to physicians to illustrate data on the quality of care provided and the costs of providing care to Medicare beneficiaries compared with their peers. In the proposed rule, CMS notes its intention to provide QRURs at the TIN level to all groups of physicians with 25 or more EPs beginning in September 2013. These QRURs will contain 2012 performance data, utilizing the VBPM methodologies using the group's PQRS measures, and VBPM outcomes and cost measures. The reports will also include information on the beneficiaries attributed to the group, and hospitalizations for these attributed beneficiaries, among other details.