Medicare Physician Fee Schedule (PFS) 2015 Final Rule:
Changes to Physician Quality Programs

Highlights

Background

On November 13, 2014, the Centers for Medicare & Medicaid Services (CMS) published the 2015 Medicare PFS Final Rule (Final Rule) in the Federal Register. The Final Rule outlines policies and payment rates for Medicare Part B physician services that are effective for calendar year (CY) 2015. This document summarizes the highlights from the 2015 Final Rule related to Medicare physician quality programs. An accompanying “Questions and Answers” document that goes into further details regarding these topics is included as Appendix 1.

Overview

CMS is continuing its implementation of Medicare physician quality initiatives, which have the potential to significantly impact physician payment over the next few years

The specific quality-related programs addressed in the Final Rule include:

- the Physician Quality Reporting System (PQRS);
- the Physician Value-Based Payment Modifier (VBPM);
- the Medicare Shared Savings Program; and
- the Physician Compare website.

Physicians should note that the various payment adjustments under the Medicare physician quality programs, most notably the PQRS, VBPM, and Medicare Electronic Health Record (EHR) Incentive Program, are additive. Therefore, a physician’s PFS payments could be reduced by as much as 9% by CY 2017, when the effects of all three of these programs are combined (see Figure 1). The quality-related payment adjustments, however, do not apply to payment for Part B drugs and biologicals administered in the physician office setting, which will continue to be paid based on the Average Sales Price methodology.
Summary of Physician Quality-Related Provisions in the 2015 Final Rule

- **Physician Quality Reporting System**
  Beginning in CY 2015, failure to participate in PQRS will result in a PFS payment reduction for “eligible professionals” of 1.5%. The PQRS began in 2007 as a way for CMS to collect data on specific disease states and financially reward physicians for reporting certain quality measures through PFS payment adjustments. The Final Rule makes changes to the PQRS quality measures and other reporting requirements. Generally, under the PQRS, eligible professionals need only report nine measures covering the three National Quality Strategy domains (note that the content of the reporting does not affect the PQRS payment adjustment). For the 2017 PQRS payment adjustment, CMS will also require that eligible professionals who see at least one Medicare patient in a face-to-face encounter report at least one “cross-cutting” measure among the other measures they report.

- **Physician Value-Based Payment Modifier**
  By statute, CMS is required to apply the VBPM to all Medicare physicians beginning in CY 2017, and physician performance on quality and cost measures in CY 2015 will be used to determine the CY 2017 payment adjustment. VBPM provides for Medicare payment adjustment to PFS rates based on physician performance on certain quality and cost measures. PQRS reporting is the basis for the VBPM payment adjustments.
The Final Rule completes the phase-in of the VBPM by applying the modifier to physicians in groups with two or more eligible professionals, as well as physicians who are solo practitioners in CY 2017.\(^6\) As a result, CMS estimates that approximately 900,000 physicians in total will be subject to the VBPM in CY 2017.\(^7\) CMS also makes a number of refinements to the CY 2017 VBPM program, most notably:

- The Final Rule increases the maximum downward payment adjustment from -2.0% in 2016 to -4.0% in CY 2017, but only for groups with 10 or more eligible professionals (note that CMS had originally proposed to apply the -4.0% downward payment adjustment to all physicians in CY 2017). Groups with fewer than 10 eligible professionals will be subject to a maximum downward payment adjustment of -2.0%.\(^8\)
- The Final Rule expands the VBPM to non-physician practitioners beginning with the CY 2018 payment adjustment.\(^9\)
- CMS will apply the VBPM adjustment to practitioners participating in the Medicare Shared Savings Program, Pioneer ACO Program, and the Comprehensive Primary Care Initiative beginning in CY 2017 (note that these practitioners were previously exempt from the VBPM).\(^10\)

**Medicare Shared Savings Program**

The Final Rule continues CMS’s recent trend of updating the quality-related aspects of the Shared Savings Program. CMS is finalizing several changes to the quality-related provisions that apply to Accountable Care Organizations (ACOs) participating in the Shared Savings Program. These changes reflect a focus on outcomes, as well as attempt to reduce providers’ reporting burden by incorporating more claims-based measures.\(^11\)

**Physician Compare Website**

CMS continues to build its Physician Compare website, which is designed to publicly report physician quality information. The website currently has some limited information on Medicare-participating physicians, as well as performance information on select quality measures for ACOs. Under the Final Rule, CMS expands the 2015 quality data that will be available for public reporting on the Physician Compare website in 2016, including all measures reported by group practices and ACOs.\(^12\)
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Appendix 1:
Medicare Physician Fee Schedule (PFS) 2015 Final Rule:
Changes to Physician Quality Programs

Questions and Answers

Background

On November 13, 2014, the Centers for Medicare & Medicaid Services (CMS) published the 2015 Medicare PFS Final Rule (Final Rule) in the Federal Register. The Final Rule outlines policies and payment rates for Medicare Part B physician services that are effective for calendar year (CY) 2015. This Questions and Answers (Q&A) document addresses changes to various Medicare physician quality programs presented in the 2015 Final Rule. A separate Q&A document focuses on the Final Rule’s coding and payment policy changes.

Q. How does the Final Rule impact the various Medicare physician quality programs?

A. The Final Rule implements a number of changes and refinements to Medicare physician quality programs and emphasizes the agency’s intent to facilitate the alignment of programs, reporting systems, and quality measures. The specific quality programs discussed in the Final Rule include:

- the Physician Quality Reporting System (PQRS);
- the Physician Value-Based Payment Modifier (VBPM);
- the Medicare Shared Savings Program; and
- the Physician Compare website.

Physicians should note that the various payment adjustments under the Medicare physician quality programs, most notably the PQRS, VBPM, and Medicare Electronic Health Record (EHR) Incentive Program, are additive. Therefore, a physician’s PFS payments could be reduced by as much as 9% by 2017 when the effects of all three of these programs are

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combined (see Figure 1 below). These payment adjustments, however, do not apply to reimbursement for Part B drugs and biologicals administered in the physician office.

![Combined potential negative payment impact of physician quality initiatives](image)

**Figure 1: Combined potential negative payment impact of physician quality initiatives**

### I. Physician Quality Reporting System (PQRS)

#### Q. What is the PQRS?

**A.** The PQRS began in 2007 as a way for CMS to collect data on specific disease states and financially reward “eligible professionals” for reporting certain quality measures through PFS payment adjustments. PQRS participants must report data on quality measures for covered PFS services furnished to Medicare beneficiaries (the content of the reporting does not affect the PQRS payment adjustment). The PQRS program is updated annually, with changes effective the first day of each new calendar year. The “performance period” (i.e., the period

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3 “Eligible professionals” include physicians, as well as certain non-physician practitioners.
during which eligible professionals report on various quality measures) is two years prior to the payment adjustment period related to that data reporting. So, for example, a physician’s reporting of PQRS quality measures in CY 2015 will determine the PQRS payment adjustment that applies to the physician’s Part B payment in CY 2017.

Through performance year 2014, eligible professionals that successfully participate in PQRS qualify for an incentive payment equal to 0.5% of the total estimated Medicare Part B PFS allowed charges for covered professional services (excluding drugs and biologicals) furnished during the applicable reporting period. Beginning in 2015, however, PQRS participation will no longer earn eligible professionals an incentive payment. Rather, the failure to participate in PQRS will result in a PFS payment reduction.4

Requirements for successful participation in PQRS are specific to the particular reporting method that the physician uses. CMS publishes various tools and resources to assist eligible professionals with PQRS. The CMS PQRS home page may be accessed at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRI/01_Overview.asp.

Q. Does the Final Rule make any changes to PQRS measures?

A. Yes, CMS makes a number of updates to the PQRS measures, including:

- revisions to the PQRS measures set;
- introduction of a new, cross-cutting measures set; and
- changes to measures groups.

Measures Set Revisions

The Final Rule revises the measures available for satisfactory PQRS reporting beginning in 2015 and beyond. CMS is adding 20 new individual measures and two measures groups, as well as removing 50 measures. This brings the PQRS individual measure set to 255 total

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measures.\textsuperscript{5} Keep in mind that, generally, eligible professionals need only report nine measures covering three National Quality domains to satisfy PQRS reporting requirements.

\textit{Cross-Cutting Measures}

The Final Rule incorporates the reporting of “cross-cutting” measures in the PQRS in order to obtain quality data on more varied aspects of a physician’s practice. Cross-cutting measures are measures that are generally not disease or condition-specific such that they can be applied across a wide range of patients. CMS plans to gradually phase-in the reporting of cross-cutting measures. Specifically, for the 2017 PQRS payment adjustment, eligible professionals and group practices reporting via claims or registry that see at least one Medicare patient in a face-to-face encounter will be required to report at least one cross-cutting measure.\textsuperscript{6} Table 52 in the Final Rule contains the complete list of the cross-cutting measures eligible for reporting beginning in 2015.\textsuperscript{7}

\textit{Measures Groups}

A measures group is currently defined as a subset of four or more PQRS measures that have a particular clinical condition or focus in common. The denominator definition and coding of the measures group identifies the condition or focus that is shared across the measures within a particular measures group.\textsuperscript{8} The Final Rule increases the number of measures for defining a measures group as a subset of six or more PQRS measures that have a particular clinical condition or focus in common, and makes several other changes to the measures groups for PQRS reporting in 2015 and beyond.\textsuperscript{9}

\textbf{Q. Does the Final Rule make any changes to the PQRS reporting vehicles/entities?}

\textbf{A.} Yes. Currently, the PQRS includes the following reporting mechanisms: claims; qualified registry; EHR; Group Practice Reporting Option (GPRO) web interface; certified survey vendors

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\textsuperscript{6} 79 Fed. Reg. 67,785.

\textsuperscript{7} 79 Fed. Reg. at 67,801-07. tbl. 52.

\textsuperscript{8} 42 C.F.R. §414.90(b).

Q. Does the Final Rule make any changes to the criteria for satisfactory PQRS reporting by eligible professionals or groups?

A. Yes. Keep in mind that reporting year 2014 was the last year in which eligible professionals can earn a PQRS incentive payment. Eligible professionals who do not meet PQRS requirements during the 2015 performance period will be subject to the 2017 PQRS payment adjustment with no exceptions. That payment adjustment is 98.5% of the PFS amount that would otherwise apply for professional services (but does not include reimbursement for drugs or biologicals) furnished by an eligible professional – in other words, a -1.5% penalty.\(^\text{11}\)

The Final Rule revises some criteria for satisfactory 2015 PQRS reporting for individuals and groups based on the applicable reporting mechanism. These changes are summarized in Tables 50 and 51 of the Final Rule.\(^\text{12}\)

II. Value-Based Payment Modifier

Q. What is the VBPM?

A. Healthcare reform required that the Secretary of Health and Human Services establish a payment modifier providing for differential payment for a physician or group of physicians based on their performance on quality of care measures compared to cost measures during a performance period.\(^\text{13}\) The modifier applies to certain physicians and physician groups beginning in 2015, and is required to apply to all physicians and physician groups beginning in 2017. The VBPM adjustment applies only to Part B physician payments made under the Medicare PFS. It does not apply to Medicare payments for drugs and biologicals. It is applied

\(^{10}\) 79 Fed. Reg. at 67,778-83.
\(^{11}\) 42 U.S.C. § 1395w–4(a)(8).
\(^{12}\) 79 Fed. Reg. at 67,796-98. tbls. 50-51.
to the Medicare paid amount at the tax identification number level, and does not impact beneficiary cost sharing.\textsuperscript{14}

The VBPM must be budget neutral, so some physician and physician groups' payments will be increased and others will be decreased, with the total level of PFS payment remaining unchanged. VBPM payment adjustments are additive to those of other Medicare physician quality programs (i.e., PQRS and the Medicare EHR Incentive Program). More information on the VBPM and links to the Quality Resource and Use Reports (QRURs), which give physicians feedback on their quality and cost performance for their patient populations in order to prepare for the VBPM, are available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

Q. How does the Final Rule affect implementation of the VBPM?

A. The Final Rule makes the following changes to the VBPM program:

- applies the VBPM to all physicians beginning in 2017;
- extends the VBPM to non-physician eligible professionals;
- requires that physicians be subject to the VBPM's “quality-tiering” methodology;
- applies the VBPM to participants in the Shared Savings Program and others;
- increases the maximum downward payment adjustment;
- revises the beneficiary attribution methodology; and
- expands the current informal inquiry process.

Group Size and Composition

The Final Rule completes the VBPM phase-in by setting forth the policies that will apply under the VBPM in 2017 and beyond to groups of two or more eligible professionals and to all solo practitioners.\textsuperscript{15} Thus, by 2017, all Medicare physicians and physician groups will be subject to the VBPM, as required by law. CMS estimates that this latest expansion of the VBPM program will affect approximately 900,000 physicians in 2017.\textsuperscript{16}

\textsuperscript{14} 42 C.F.R. § 414.1205.
\textsuperscript{15} 79 Fed. Reg. at 67,936.
\textsuperscript{16} 79 Fed. Reg. at 67,933.
Expanding the VBPM to Non-Physician Eligible Professionals

The Final Rule expands the application of the VBPM to non-physician eligible professionals (i.e., nurse practitioners, physician assistants, physical therapists, and others) in groups with two or more eligible professionals and to solo practitioner eligible professionals beginning with the CY 2018 payment adjustment period.\(^{17}\) Note that CMS had originally proposed to extend the VBPM to non-physician eligible professionals beginning with the CY 2017 payment adjustment, but delayed the start date to give non-physicians more time to become familiar with the program.

Mandatory Quality-Tiering

Under the VBPM program’s so-called “quality-tiering” methodology, physicians are subject to an upward, neutral, or downward payment adjustment depending on their performance on certain quality and cost measures compared to national benchmarks.\(^ {18}\) The Final Rule makes quality-tiering mandatory for all physicians in 2017. CMS will hold the newest VBPM participants – groups comprised of between two and nine eligible professionals and solo practitioners – harmless from any downward payment adjustment in 2017.\(^ {19}\) In other words, these physicians will be subject to upward or neutral adjustments under the quality-tiering methodology, but will not be subject to downward adjustments for poor quality and cost performance.

Participants in the Shared Savings Program, Pioneer ACO Program, and the Comprehensive Primary Care Initiative

For the CY 2015 and 2016 payment adjustments, groups of physicians participating in the Shared Savings Program, Pioneer ACO Program, or other similar CMS or CMS Innovation Center initiatives, are not subject to the VBPM.\(^ {20}\) Under the Final Rule, beginning with the CY 2017 payment adjustment, the VBPM will apply to all physicians, including those that participate in an ACO under the Medicare Shared Savings Program, the Pioneer ACO program, and the Comprehensive Primary Care Initiative during the relevant performance period (with some minor modifications to their performance scoring).\(^ {21}\)

\(^{17}\) 79 Fed. Reg. at 67,937.
\(^{18}\) 42 C.F.R. § 414.1275.
\(^{19}\) 79 Fed. Reg. at 67,941.
\(^{20}\) 42 C.F.R. § 414.1210.
Payment Adjustments

The Final Rule increases the downward adjustment under the VBPM by doubling the amount of payment at risk from 2.0% in CY 2016 to 4.0% in CY 2017 for failure to report under the PQRS. In other words, CMS will apply a negative 4.0% adjustment to physicians who do not meet PQRS reporting requirements in CY 2015. CMS will also increase the CY 2017 maximum downward adjustment under quality-tiering to -4.0% for practitioners classified as "low quality/high cost". Notably, however, CMS sets a maximum adjustment of -2.0% in 2017 for solo practitioners and groups with fewer than 10 eligible professionals who do not meet the reporting requirements under the PQRS. As noted above, solo practitioners and groups with fewer than 10 eligible professionals who meet PQRS reporting requirements will be subject to only neutral or upward payment adjustments (but not negative payment adjustments) under quality-tiering in CY 2017.

The Final Rule also increases the maximum upward adjustment for groups of 10 or more eligible professionals under the quality-tiering methodology in CY 2017 to +4.0x for those groups classified as "high quality/low cost." For groups with fewer than 10 eligible professionals and solo practitioners, CMS set the maximum upward adjustment at +2.0x for "high quality/low cost." Note that the "x" represents the upward adjustment factor, which is calculated after the negative adjustments have been applied in order to keep the VBPM program budget neutral, as required by the statute.

Beneficiary Attribution

The Final Rule modifies the current beneficiary attribution methodology, as well as eliminates the current exclusions of certain part-year Medicare beneficiaries. These policies apply to the per capita cost measures and (in the case of the attribution methodology) to claims-based quality measures used under the VBPM program.

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Informal Inquiry Process

Currently, physicians cannot seek administrative or judicial review of VBPM determinations, and CMS’s current informal inquiry process is limited. The Final Rule expands this informal inquiry process and establishes an initial process that will allow for some limited corrections to be made to the quality and cost data that serve as the basis for VBPM adjustments. For the 2015 payment adjustment, the deadline for requesting corrections of a perceived error by CMS is February 28, 2015. Beginning with the 2016 payment adjustment period, the deadline for physicians to request corrections will be 60 days after the release of the QRURs for the applicable performance period. CMS will recalculate a physician’s or physician group’s cost score if it determines an error was made. However, CMS is still currently working to establish the operational infrastructure that will allow it to correct errors related to the quality measure data. Until that process is developed, CMS will designate a physician or group as “average quality” in the event that an error is discovered in the calculation of the physician’s quality score.

Q. Does the Final Rule make any changes to composition of the VBPM cost measures?

A. Medicare Part A and Part B costs are included in the VBPM total per capita cost measures and the Medicare Spending per Beneficiary (MSPB) measure. Medicare Part D costs are not included. The Proposed Rule acknowledged the complexities of including Part D costs in these cost measures. In the Final Rule, CMS addresses stakeholder comments and proposals on this issue, but does not make any changes. The agency notes, however, that it is “actively investigating options for operationally including Part D costs” in the VBPM cost measures, and will propose any viable options in future proposed rules.

III. The Medicare Shared Savings Program

Q. What is the Medicare Shared Savings Program?

A. CMS established the Shared Savings Program to facilitate coordination and cooperation among providers in order to improve the quality and efficiency of care for Medicare FFS

27 42 C.F.R. §§ 414.1280; 414.1285.
beneficiaries. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by establishing an ACO. The Shared Savings Program is designed to improve beneficiary outcomes and increase the value of care by:

- promoting accountability for the care of Medicare FFS beneficiaries;
- requiring coordinated care for all services provided under Medicare FFS; and
- encouraging investment in infrastructure and redesigned care processes.

The Shared Savings Program rewards ACOs that reduce costs for their patient population while also meeting performance standards on quality of care. Participation in an ACO is voluntary.31

Q. Does the Final Rule make any changes to ACOs?

A. Although the Shared Savings Program is largely implemented through separate regulations, over the past few years, CMS has addressed certain quality-related provisions related to ACOs in the annual PFS rulemaking. Citing ongoing efforts to align quality measurement and reporting under the Shared Savings Program with other Medicare quality programs (e.g., PQRS and the EHR Incentive Program), CMS has once again included several quality-related provisions for ACOs in the 2015 PFS Final Rule.

Quality Measures and Performance Standard

The Final Rule changes the ACO quality measures to include more of a focus on outcomes, as well as attempt to reduce providers’ reporting burden by incorporating more claims-based measures.32 Thus, CMS is revising the quality measures that are reported by ACOs, although the total number of measures will continue to be 33. The measures that will be used in establishing the quality performance for ACOs are found in Table 81 of the Final Rule.33

Other Shared Savings Program Quality-Related Provisions

The Final Rule contains additional proposals related to the Shared Savings Program:

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• CMS is modifying the benchmarking methodology for “topped out measures” – i.e., those for which all but a few organizations achieve near perfect scores. The new method uses an alternative methodology to establish the benchmark when the national Medicare FFS data result in the 90th percentile being greater than or equal to 95%.  

• CMS is revising the existing quality scoring strategy to explicitly recognize and reward ACOs that make year-to-year improvements in their quality performance scores on individual measures. This methodology adds a quality measure that awards bonus points for improvement on each of the existing four quality measure domains. Up to four additional bonus points will be awarded to each domain for quality performance improvement on the measures within that domain.

IV. Physician Compare

Q. What is Physician Compare?

A. Healthcare reform requires that physician quality performance information, including that collected under PQRS and related to patient experience of care, be made publicly available through the Physician Compare website. Launched in late 2010, Physician Compare (http://www.medicare.gov/physiciancompare/search.html) has evolved using a phase-in approach, gradually increasing the amount and type of information that is publicly available regarding Medicare physicians. Currently posted on the website are the names of individual eligible professionals who satisfactorily report under the PQRS, eligible professionals who are successful electronic prescribers under the Medicare Electronic Prescribing (eRx) Incentive Program, and successful participants in the Medicare EHR Incentive Program. Quality performance reporting is in the early stages, and, so far, consists of reporting only at the group level. Performance scores are publicly available on the website for five PQRS GPRO diabetes and heart disease measures for group practices and Shared Savings Program ACOs that satisfactorily participated in these programs in 2012.

36 ACA § 10331(a)(2).
CMS has announced plans to expand the quality measures posted on Physician Compare with public reporting in CY 2015 of performance data on all measures collected through the GPRO web interface for groups of all sizes participating in 2014 under the PQRS GPRO and ACOs under the Shared Savings Program. CMS also plans to publicly report group performance on certain PQRS measures submitted in 2014 via registries and EHRs, including patient experience of care.38

Q. **Does the Final Rule make any changes to Physician Compare?**

A. Yes. CMS continues the expansion of public reporting on Physician Compare by preparing to make even more quality measures collected in 2015 publicly available on the web site in 2016, including:

- all 2015 PQRS GPRO measure sets across group reporting mechanisms – GPRO web interface, registry, and EHR – for groups of two or more eligible professionals;
- all measures reported by Shared Savings Program ACOs;
- all 2015 PQRS individual measures collected via registry, EHR, or claims (with the exception of new PQRS measures in their first year);
- 2015 CAHPS survey data for PQRS for group practices with two or more eligible professionals, as well as CAHPS data for ACOs; and
- individual eligible professional-level 2015 QCDR data (with some limitations).39

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