Summary of the CY 2015 Medicare Physician Fee Schedule Proposed Rule

On July 3, 2014, the Centers for Medicare and Medicaid Services (CMS) released the CY 2015 Medicare Physician Fee Schedule (PFS) and Clinical Laboratory Fee Schedule (CLFS) Proposed Rule, outlining proposed payment rate and policy changes impacting physician and laboratory reimbursement for Medicare Part B services beginning January 1, 2015.

Regarding its impact on the laboratory and pathology community, this year’s Proposed Rule is rather unique for the following reasons:

1.) **Overall Economic Impact on Pathologists and Laboratories is POSITIVE:** Over the past few years, the pathology and laboratory community have endured, or at the very least been threatened by, dramatic cuts to reimbursement via the payment rates and policies proposed and/or finalized in the annual PFS/CLFS. However, this year, the overall impact on pathologists is actually rather favorable, estimated at one percent ($1.07 billion) of total Medicare Part B allowed charges. Similarly, the overall impact on independent laboratories is estimated at three percent ($703 million) of total allowed charges. Conversely, last year’s estimated impacts were -5 percent and -26 percent, respectively.

2.) **Omitted Policy May be of Greater Significance than Policies Actually Included:** In a major and unexpected victory for the laboratory and pathology community, CMS did not revisit the “OPPS Cap Proposal,” as it previously stated that it had intended to do in last year’s PFS Final Rule. Under the proposal, CMS had proposed to cap PFS payment rates at hospital payment rates when the former exceeded the latter for a given service. ASCP adamantly opposed this proposal and, in response, led a very successful e-advocacy campaign resulting in nearly 10,000 messages to CMS and Congress in opposition to it. ASCP is extremely pleased that CMS has finally realized that the “comparison of OPPS (or ASC) payment amounts to PFS payment amounts for particular procedures is not the most appropriate or effective approach to ensuring that PFS payment rates are based on accurate cost assumptions.” Nonetheless, ASCP notes CMS’s lingering concerns regarding the up-to-date accuracy and accessibility of the resource data needed to validate and/or update PFS payment rates. This is evident in CMS’s request for comment on the best data collection approaches for yielding updated data from physician practices. However, though CMS recognizes commenters concerns with using OPPS/ASC payment amounts as benchmarks for PFS payment rates – given that they reflect average rates/relative weights rather than direct cost inputs – the Agency is still interested in using outpatient hospital cost data as a benchmark for pricing non-facility based Medicare services and seeks comment accordingly.

3.) **Significant Legislative Overlap Considerations and Implications:** The annual publication of the PFS occurs through the federal government’s regulatory process. It is typically completely separate from the legislative process, though often times CMS’s regulatory authority is restricted by what is “set in statute” via legislation. Hence, Congress’s April 1st passage of H.R. 4302, The Patient Access to Medicare Act, significantly impacts the content of this year’s PFS. First, there is little mention of the -20.9 percent PFS update threatening physicians’ Medicare reimbursement as a result of the Sustainable Growth Rate (SGR) payment formula because PAMA averts this cut through March 2015. Second, PAMA repealed CMS’s authority to revalue the CLFS payment rates based on technological change, as previously finalized in last year’s PFS Final Rule, and replaced the revaluation process with a market-based approach that relies on the collection of test-specific price and volume information from private sector payors. Hence, CMS does not touch upon this now statutory-based proposal in this year’s PFS. Additionally, PAMA established nine additional categories for review when identifying potentially misvalued codes, which may have significant additional impact on the type and number of codes up for review when added to the existing seven categories.

4.) **Unprecedented Transparency and Stakeholder Involvement in Payment Rate-Setting:** This year, CMS is placing unprecedented emphasis on large-scale, cost-based data collection and payment rate-setting transparency. Accordingly, in lieu of merely dictating changes to payment rates that have already been decided upon behind closed doors, the Agency is exerting its newly enhanced information collection authority via PAMA and reforming its existing timeline for misvalued code nominations and proposals to improve information transparency and increase opportunity for stakeholder input. As such, beginning with the CY 2016 PFS Proposed Rule, CMS will include all CMS-proposed values and all values proposed by the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) that have been received by January 15, 2015. Values proposed by the RUC, but not received by CMS by this date, will be delayed for consideration for one year and included in the following year’s PFS Proposed Rule in order to allow sufficient time for public comment.
Key Provisions in the CY 2015 Medicare PFS:

Local Coverage Determination Process for Clinical Diagnostic Laboratory Testing

In this proposal, CMS responds to PAMA’s specification that local coverage decisions (LCDs) are to be the mandated vehicle for local coverage policies for clinical diagnostic laboratory tests. Recognizing the need for immediate reform, CMS addresses the challenges experienced throughout the recent molecular pathology valuation process and looks to the National Coverage Determination (NCD) process as a more efficient model for an expedited LCD process. Accordingly, while CMS believes some key aspects of the LCD process should be maintained, such as allowing public comment to draft LCDs, and MAC responses to public comments, the Agency believes there is significant opportunity for streamlining it. The goal of this proposal is to balance the need to allow enough time for notification of stakeholders and public dialogue with the need to finalize a large number of LCDS in a timely manner in order to expedite beneficiary access to covered clinical diagnostic laboratory tests. Reference Table 18: Comparison of Current LCD Process versus Proposed LCD Process for Clinical Diagnostic Laboratory Tests below.

<table>
<thead>
<tr>
<th>Current LCD Process</th>
<th>Proposed LCD Process for Clinical Diagnostic Laboratory Tests</th>
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<tbody>
<tr>
<td>Issue Draft LCD in Medicare Coverage Database, which identifies criteria used for determining coverage under statutory “reasonable and necessary” standard</td>
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<tr>
<td>Public comment period of 45 calendar days</td>
<td>Public comment period of 30 calendar days with option to extend</td>
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<tr>
<td>Present LCD at CAC &amp; discussion at open stakeholder meetings</td>
<td>Optional CAC meeting. No requirement for open stakeholder meeting</td>
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<tr>
<td>Publication of Comment/Response Document and final LCD (no specified time of publication after the close of the comment period)</td>
<td>Publication of Comment/Response Document and final LCD within 45 calendar days of the close of the draft LCD comment period</td>
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<tr>
<td>Notice period of 45 calendar days with the final LCD effective the 46th calendar day</td>
<td>Final LCD effective on the date of publication</td>
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<tr>
<td>Interested parties may request reconsideration of an LCD</td>
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<td>An aggrieved party may further challenge an LCD</td>
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Potentially Misvalued Codes:

**Flow cytometry/tc add-on:** CMS has identified 65 codes as a prioritized subset of potentially misvalued codes of the newly established statutory category finalized with the passage of PAMA, entitled “codes that account for the majority of spending under the PFS.” The majority of spending is defined as greater than or equal to $10 million in allowed charges. Accordingly, only one pathology code was identified via this methodology: CPT Code- HCPCS 88185, Flow cytometry/tc add-on. Nonetheless, CMS actually proposes to increase reimbursement for this code by 5.3 percent (1.5→1.58 RVUs) this year, as proposed in the CY 2015 PFS Proposed Rule’s Addendum B – Relative Value Units and Related Information.

**Prostate Biopsy Codes – HCPCS codes G0416, G0417, G0418, and G0419:** In the CY 2014 PFS, CMS finalized its decision to modify the code descriptors for G0416 through G0419 so that the codes could be used for routine prostate biopsies, rather than solely for saturation prostate biopsies. ASCP disputed this proposal because it would bundle multiple routine prostate biopsies at a single rate, under the false assumption that in doing so efficiencies could be gained, as is the case for saturation prostate biopsies. Nonetheless, under the premise that the number of specimens associated with prostate biopsies is relatively homogenous, this year CMS is proposing to eliminate all of the g-codes except for G0416, which assumes the lowest number of specimens evaluated for prostate biopsies (10-20 specimens/biopsy). Based on review of medical literature and claims data, CMS maintains that the appropriate number of specimens reviewed per biopsy is typically between 10 and 12. Therefore, the Agency is proposing G0416 as a potentially misvalued code and seeks comment on the appropriate work RVUs, work time, and direct practice expense (PE) inputs. Currently G0416 is paid at $651.26.

Physician Quality Reporting System (PQRS)

Established in 2007, PQRS is a pay for reporting program that provides a combination of incentive payments and negative payment adjustments to promote provider reporting of quality information during patient encounters. All physicians and select non-physician practitioners that furnish covered PFS services for Medicare Part B Fee-for-Service (FFS) beneficiaries are eligible to participate in the program. Accordingly, PQRS bonus and penalty payments are calculated each year based on a specified percent of each Eligible Professional (EP)’s Medicare Part B allowed charges.

This year, CMS’s proposals focus primarily on the CY 2017 payment adjustment, based on the CY 2015 reporting period, as well as the Agency’s efforts to align quality reporting programs, specifically through the Qualified Clinical Data Registry (QCDR) reporting mechanism. It should be noted that since CY 2014 was the last reporting period in which EPs...
could earn an incentive payment, quality reporting requirements for the CY 2015 reporting period are focused solely on avoiding application of the -2 percent CY 2017 payment adjustment. Lastly, in this proposed rule, CMS seeks comments broadly regarding whether or not the Agency should allow more frequent submission of data, such as quarterly or year-round submissions, rather than having only one opportunity to submit quality measures data as is the case under the current process.

**CY 2015 PQRS Measure Set:** For CY 2015 there is a total of 240 total measures following the addition of 28 new measures and two measures groups and the removal of 73 measures. Additionally, three pathology-specific measures have been added to the PQRS measures set for CY 2015 Reporting:

1. **Lung Cancer Reporting (Biopsy/Cytology Specimens):** Pathology reports based on biopsy and/or cytology specimens with a diagnosis of non-small cell lung cancer classified into specific histologic type or classified as NSCLC-NOS with an explanation included in the pathology report

2. **Lung Cancer Reporting (Resection Specimens):** Pathology reports based on resection specimens with a diagnosis of primary lung carcinoma that include the pT category, pN category and for non-small cell lung cancer, histologic type

3. **Melanoma Reporting:** Pathology reports for primary malignant cutaneous melanoma that include the pT category and a statement on thickness and ulceration and for pT1, mitotic rate

**Changes to/Enhanced Reporting Requirements Proposed for CY 2015 (to Avoid Application of CY 2017 Payment Adjustment):**

**Individual Reporting:** For EPs reporting individually via claims or qualified registry that wish to avoid the CY 2017 payment adjustment, the CY 2014 reporting requirements for earning an incentive payment apply (9 measures across 3 NQS domains) again in CY 2015. However, in CY 2015, if the EP sees at least one Medicare patient in a face-to-face encounter, the EP is required to report on two additional measures contained in this year’s newly proposed cross-cutting measures set, serving as somewhat of a core measures set. For individual reporting via the QCDR, the EP is required to report each of 9 measures, covering at least 3 NQS domains, for at least 50 percent of his/her patient population, including three outcomes measures. If three outcomes measures are not feasible, the EP must report on one outcomes measure, but may substitute the two remaining outcomes measures with the following possible types of measures: resource use, patient experience of care, or efficiency/appropriate use.

**Group Reporting:** First, beginning in CY 2015, groups of EPs that wish to participate in PQRS as a group, must register to participate in the Group Practice Reporting Option (GPRO) by June 30th of the year in which the reporting period occurs (i.e. June 30, 2015), rather than September 30th. Also for CY 2015, CMS proposes that group practices of 25+ EPs must all report measures on 248 patients. This single figure patient reporting requirement is opposed to the bifurcated requirements previously specifying 411 patients for groups of 100+ EPs and 218 patients for groups of 25-99 EPs. Accordingly, CMS proposes to adopt the attribution methodology changes proposed for the value-based payment modifier (VBM) program in this year’s proposed rule into the GPRO web interface beneficiary assignment methodology for CY 2015.

Additionally for CY 2015, CMS proposes that group practices that report via registries that include at least one EP that has at least one face-to-face patient encounter during the reporting period will be required to report on at least two of the cross-cutting measures mentioned in the individual reporting requirements above. This requirement will be reduced to one cross-cutting measure for groups that report both via registries and a certified survey vendor. Lastly, also beginning in CY 2015, CMS proposes to require all groups of 100+ EPs to report the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS survey measures. Reporting these survey measures will remain optional for groups of 2-99 EPs in CY 2015. Nonetheless, the Agency notes that it will no longer be able to fund this initiative for any size group of EPs this coming year.

**Qualified Clinical Data Registry (QCDR) Requirements:**

- **Measures:** As mentioned above, beginning in CY 2015, CMS is requiring EPs reporting via QCDRs to reporting on three outcomes measures. If this is not possible, EPs must report on at least one outcomes measure and may substitute the remaining two measures with resource use, patient experience of care, and/or efficiency/appropriate use measures. CMS is also increasing the number of non-PQRS measures allowed for reporting via a QCDR from 20 to 30.
In the CY 2014 PFS Final Rule, CMS finalized the proposal that if the Agency is unable to attribute a sufficient number of beneficiaries to a group of physicians subject to the value modifier, and thus, are unable to calculate any of the cost measures with at least 20 cases, then the group’s cost composite score would be classified as “average” under the quality-tiering methodology. In this year’s proposed rule, CMS proposes to apply this same policy for solo practitioners beginning in CY 2017.
receive a downward adjustment, and approximately 83 percent of all EPs would receive no payment adjustment in CY 2017.

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

* Individual EPs and groups of EPs 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; “x” determined after performance period has ended based on the aggregate amount of downward payment adjustments.

Overlap of Accountable Care Organizations (ACOs) and the VBM Program: As mentioned above, beginning in CY 2017, CMS will begin applying a value modifier to individual EPs and groups of EPs participating in ACOs. As of April 1, 2104, CMS estimates that there are 338 ACOs participating in its Shared Savings Program, including 31 ACOs that consist of only one ACO participant TIN. Unlike the VBM program, which groups EPs at the TIN-level, there can be multiple TINs grouped within a single ACO. Despite conceptual integration efforts between these two programs, there are some programmatic differences that remain and thus affect the implementation of operational integration efforts. For example, the two programs have two very methodologically dissimilar approaches to calculating cost benchmarks. Accordingly, beginning in CY 2015, CMS proposes that classify the cost composite for the value modifier as “average cost” for groups of EPs participating in ACOs during the payment adjustment year (CY 2017). It should be noted, that CMS has a staunch policy to not “track” or “carry over” an individual EPs performance from one TIN to another for any of its quality reporting programs. Therefore, payment adjustments/quality-tiering is always applied to EPs within a TIN during the payment adjustment year, even if the EP was not employed within the TIN during the performance period year. This may not seem fair; however, CMS cites administrative tracking that would not be feasible. CMS will publish a final list of ACOs (including their participant TINs) that will participate in ACOs during the CY 2015 payment adjustment period during the late fall of CY 2014, period to the onset of the payment adjustment period.

Clarification Regarding the Exclusion of Non-Assigned Claims for Non-Participating Providers from the VBM program: In the CY 2013 PFS Final Rule, CMS finalized its proposal to apply the value modifier to Medicare paid amounts for the items and services billed under the PFS at the TIN level so that beneficiary cost-sharing would not be affected. CMS wishes to uphold this policy but notes that it did not directly address whether the value modifier would be applied to all assigned services for which Medicare makes payment to the physician, and to non-assigned services for which Medicare makes payment to the beneficiary. If the value modifier were to be applied to non-assigned services, then the Medicare payment to a beneficiary would be increased when the value modifier is positive and decreased when the value modifier is negative. Accordingly, CMS proposes to clarify that it would apply the value modifier only to assigned services and not to non-assigned services beginning in CY 2015. Further, if CMS’s proposal to expand application of the value modifier to non-physician EPs is finalized, CMS clarifies that it would likewise apply the value modifier only to services billed on an assignment-related basis and not to non-assigned services.

Quality Measures: For CY 2015, CMS proposes to include all of the PQRS GPRO reporting mechanisms available to groups for the PQRS reporting periods in CY 2015 and all of the PQRS reporting mechanisms available to individual eligible professionals for the PQRS reporting periods in CY 2015. However, regarding individual reporting via the QCDR, CMS proposes to apply the policy previously applied to new measures under PQRS to QCDR-developed measures: if a measure is new to PQRS, CMS is unable to calculate a benchmark and therefore performance on that measure will not be included in the quality composite score. Further, also in the CY 2015 PFS Proposed Rule, CMS proposes to use PQRS GPRO Web Interface measures and the “all-cause hospital readmissions” measure because all of these measures are relatively identical across the two programs. For non-ACO participants being assessed under the VBM program, CMS proposes to change the reliability policy with respect to the “all-cause hospital readmissions” measure by increasing the minimum number of measures required to report on the measure from 20 to 200 for CY 2015. Accordingly, if a group has fewer than 200 cases for a measure in a performance period, that measure is excluded from its domain and the remaining measures in the domain are given equal weight. However, for ACO participants being assessed under the VBM program, CMS proposes to defer to the “all-cause hospital readmissions” measures specifications as established under the Medicare Shared Savings program.

Expansion of the Current Informal Inquiry Process: CMS wishes to align with PQRS to consider requests for informal review of whether a group or solo practitioner successfully reported under the PQRS program and requests for reconsideration of PQRS data. CMS also wishes to expand its current informal inquiry process to accept requests from
groups and solo practitioners to review and correct certain other errors, such as errors pertaining to eligibility or standardized score calculations. However, CMS does not believe that there is currently the infrastructure in place to support broad-level expansion. Nonetheless, for CY 2015 payment adjustment period, CMS proposes to establish a deadline of January 31, 2015 for a group to request correction of a perceived error made by CMS in the determination of its CY 2015 value modifier payment adjustment. CMS also seeks comment on an alternate deadline no later than February 2015. CMS specifies that it does not believe it operationally feasible at this time to fully evaluate errors related to quality measure data and therefore in the case that an error is dictated, CMS proposes to classify a TIN as “average quality.” However, CMS proposes to recompute a TIN’s cost composite and adjust the TIN’s quality tier in the case of related errors detected in these areas.

**Patient Attribution Methodology Changes for Total Per Capita Cost Measures (in response to NQF Concerns):** In January 2013, CMS submitted the VBM program’s total per capita cost measure for National Quality Forum (NQF) endorsement. However, September 2013, the NQF Cost and Resource Use Committee narrowly voted against the measure. In response to NQF’s concerns with the measure, CMS is proposing modifications to its two-step attribution methodology as applied to the five total per capita cost measures, as well as the claims based quality measures in the VBM program. In particular, in this year’s proposed rule, CMS is proposing to move non-physician practitioners from Step 2 to Step 1, when assessing the practitioner that has provided the plurality of primary care services. This is in lieu of limiting Step 1 of the attribution process to physicians rendering the plurality of primary care services. Additionally, CMS proposes to eliminate the pre-step of this attribution process, which identifies the pool of assignable beneficiaries that have had at least one primary care service furnished by a physician in a group, citing that this would streamline the process. Also in the CY 2015 PFS Proposed Rule, the Agency is also proposing to reverse the current exclusion of certain Medicare beneficiaries during the performance period. This is in response to NQF concerns that end-of-life costs were not being captured by the total per capita cost measure. Accordingly, CMS proposes to include certain part-year Medicare Fee-for-Service (FFS) beneficiaries, including Medicare FFS beneficiaries who are newly enrolled to Medicare.

**Treatment of Hospital-based Physicians with Regard to the VBM Program:** CMS is considering including or allowing groups that include hospital-based physicians or solo practitioners who are hospital-based to elect the inclusion of Hospital Value-Based Purchasing (VBP) Program performance in their VM calculation in future years of the program. This consideration is in response to commenters past suggestions, noting that there are limited measures that apply to certain specialties and that those specialties may exercise wide influence over the quality of care provided in a hospital. Because the value modifier is applied at the TIN level, CMS believes that the election to include Hospital VBP Program data must also be made at the TIN level. Accordingly, CMS considers two approaches for identifying which TINs represent hospital-based physicians and should therefore have Hospital VBP program data included or have the option to elect its inclusion: 1.) voluntary self-nomination; 2.) CMS-specified TIN eligibility criteria. Other considerations regarding the potential application of hospital performance data to TINs are as follows:

- **Eligibility Criteria:** Would the inclusion of hospital performance data criteria have to apply to the majority of physicians within a given TIN or would the TIN, as a whole, have to meet the criteria in the aggregate?
- **Hospital Data Attribution Methodology:** What is the best methodology to determine which hospital or hospitals’ performance would apply to a given TIN? Plurality of services/meeting a specific threshold of services performed at a specific hospital?
- **Calculating a Value Modifier for a TIN with Multiple Hospitals’ Performance Data Assessed:** Should CMS weight the performance of the hospitals included, based on Medicare dollars paid to the TIN for services their providers furnished to beneficiaries hospitalized at a given hospital, or based on number of cases treated by providers from the TIN that are discharged from a given hospital?
- **Strategic Incorporation of Hospital(s)’s Top Performance Scores (TPS)** – the weighted total of underlying quality performance scores the hospital receives on quality and efficiency measures included in the program: Should CMS: (1) Include the entire TPS in the cost composite; (2) Include the Efficiency and Cost Reduction domain score in the cost composite, and include all or some subset of the other domain scores in the quality composite; or (3) Include some subset of the measures in the cost and quality composites?

**Physician Feedback Program**

On September 16, 2013, CMS made available to all groups of 25+ EPs an annual Quality Resource Use Report (QRUR) based on CY 2012 data to help groups estimate their quality and cost composites under the VBM program. CMS intends to make reports based on CY 2013 data available in the fall of 2014. Improvements to this year’s reports include:
additional supplementary information on the specialty adjusted benchmarks; inclusion of the individual PQRS measures for informational purposes for individual EPs reporting PQRS measures on their own; enhanced drill down tables; and a dashboard with key performance measures.

Moreover, in June 2013 and June 2014, CMS provided Supplemental QRURs to group report recipients that featured episode-based costs of care. Accordingly, CMS is statutorily required to develop an episode grouper and include episode-based costs in the QRURs. CMS specifies that an episode of care consists of medical and/or procedural services that address a specific medical condition or procedure that are delivered to a patient within a defined time period and are captured by claims data. An episode grouper organizes administrative claims data into episodes. In CMS’s 2012 Supplemental QRURs, the Agency:

- Expanded the clinical conditions associated with episode groups to include chronic congestive heart failure (CHF); chronic obstructive pulmonary disease (COPD)/asthma; acute COPD/asthma; permanent pacemaker system replacement/insertion; and bilateral cataract removal with lens implant
- Broke down episode types into 20 subtypes. Accordingly, in the CY 2015 PFS Proposed Rule, the Agency is now proposing a single plurality attribution rule with a 20 percent minimum threshold for these episodes
- Included six additional clinical episode-based measures that were adapted from measures proposed for future inclusion in the Hospital VBP program. CMS seeks comment regarding whether to include these measures in the VBM program through future rule-making.

In the future, CMS specifies that it is considering proposing to add episode-based payment measures to the VBM program through future rulemaking for all 12 episode subtypes, or some subset of these episode subtypes, of the selected respiratory and selected heart conditions that have appeared in both the 2011 Supplemental QRURs and 2012 Supplemental QRURs. Additionally, CMS is considering proposing to add hospital episode-based payment measures to the VM at a later time.

**Accountable Care Organizations (ACOs)**

The Medicare Shared Savings Program was established to facilitate coordination and cooperation among Medicare enrolled providers and suppliers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce the rate of growth in health care costs through participation in an Accountable Care Organization (ACO).

**Additional Quality Improvement Reward:** CMS proposes to revise its quality scoring strategy to recognize and reward ACOs that make year-to-year improvements in quality performance scores on individual measures by adding a quality improvement measure that adds bonus points to each of the four quality measure domains based on improvement

**Revisions to Quality Measures Benchmarks:** In response to stakeholder feedback regarding “topped out” measures, CMS proposes to modify its benchmarking methodology to use flat percentages to establish the benchmark for a measure when the national FFS data results in the 90th percentile being greater than or equal to 95 percent

**Modifications to the Quality Reporting Standard’s Quality Measures:** For CY 2015, CMS proposes to increase the total number of measures available for reporting from 33 to 37 measures. The proposed changes increase the number of measures calculated through claims and decrease the number of measures reported by the ACO through the GPRO Web Interface. In general, CMS proposes revisions to reflect up-to-date clinical guidelines and practice, reduce duplicative measures, increase focus on claims-based outcome measures, and reduce ACO reporting burden. Specifically, new measures would be added to focus on avoidable admissions for patients with multiple chronic conditions, heart failure and diabetes; depression remission; all cause readmissions to a skilled nursing facility; and stewardship of patient resources; the existing composite measures for diabetes and coronary artery disease would also be updated.