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AANS/CNS Impact on CMS' 2015 MPFS Final Rule

On October 31, 2014, the Centers for Medicare & Medicaid Services (CMS) announced the 2015 Medicare Physician Fee Schedule (MPFS) Final Rule.

Overall, the non-quality related payment changes result in a net **1.0% increase** in payments to neurosurgeons for 2015 provided Congress acts to prevent a 21 percent cut in the sustainable growth rate (SGR) formula by next March 31, 2015.

Most significantly, CMS announced its intention to finalize a far-reaching plan to transition all global surgery services to 0-day global periods, beginning with 10-day global services in 2017 and following with 90-day global service in 2018. CMS will provide additional details in its proposed 2016 Medicare Physician Fee Schedule rule, which it will release in July 2015. This initiative is likely to result in substantial reductions in surgical fees.

Other provisions of interested include changes to the schedule for implementing values for new and revalued codes. Per the final rule, new values will be included in the proposed rule released annually in July, rather than waiting until the final rule, which is typically released on or before November 1. The AANS and CNS supported this change, which will allow additional time for review and comment. For 2016, CMS will strive to include as many codes as possible in the proposed rule, with full implementation of the new policy in 2017.

The rule also finalizes multiple significant changes to several federal quality reporting initiatives. Physicians who fail to satisfy the Physician Quality Reporting System (PQRS) will be subject to a -2.0% Medicare payment penalty in 2017. Despite pushback from organized neurosurgery, CMS removed many measures that will affect a neurosurgeon's ability to satisfy reporting requirements in a meaningful manner, including the Perioperative Care measures set, and the Back Pain measures set. CMS also upped the reporting requirements for 2015 to nine measures, including one "cross-cutting" measure, for 50% of applicable Medicare Part B patients. Unfortunately, the "cross-cutting" measure set is primary care-focused and of little relevance to neurosurgery. Individuals reporting via a Qualified Clinical Data Registry (QCDR) in 2015 will be required to report on nine measures, including two outcomes measures, for 50% of all applicable patients seen over the reporting period (both Medicare and non-Medicare). Organized neurosurgery, through the NeuroPoint Alliance, continues to evaluate the possibility of becoming a QCDR, which would offer neurosurgeons the opportunity to report on more meaningful quality measures.

As required by statute, CMS will apply the Value-Based Payment Modifier (VBM) to all physicians in 2017, based on 2015 quality and cost measure data. CMS finalized its decision to double the amount of payment at risk for large practices with 10 or more eligible professional to -4.0%. However, due to widespread concerns about rapid implementation, solo practitioners and smaller practices with 2-9 physicians will only face a -2.0% penalty for failing to participate in the PQRS in 2015. Futhermore, these physicians will be held harmless from downward performance-based payment adjustments in 2017. Since the VBM is tied to PQRS measures, as well as broad-based cost measures that do not reflect care decisions in the control of individual specialists, the impact of these penalties is concerning.

Finally, CMS continues to pursue an aggressive timeline for publicly reporting quality measure data on its Physician Compare website. By 2016, CMS intends to report on all PQRS individual measures collected via registry, EHR, or claims in 2015.

The AANS and CNS continue to remind CMS and Congress about the critical lack of available specialty-specific measures. This is especially problematic given that the PQRS program is transitioning to a penalty-only program, the VBM penalties continue to rise, and public accountability is increasing.

For more details, please see the following side-by-side chart, which compares the AANS and CNS comments and final provisions of the 2015 rule:

TOPIC	PROPOSAL	AANS/CNS COMMENT	OUTCOME
Resourced-Based Relative Value Units (RBRVS) for Practice Expense (PE)			
SRS Codes	Based on comments that CMS received in response to the 2014 Medicare Physician Fee Schedule (MPFS) final rule, CMS proposed to eliminate separate codes for robotic versus non-robotic linac-based SRS delivery services that were previously reported with HCPCS G-codes. In the 2014 final rule, CMS had asked whether PE RVUs for the codes should be reviewed.	Agreed that SRS and Stereotactic Body Radiotherapy (SBRT) delivery services are appropriately captured with CPT codes 77372 and 77373. Agreed with the CMS decision to accept RUC-passed direct PE inputs for CPT codes 77372 and 77373 as reflecting the typical resource inputs involved in furnishing an SRS service. Urged the agency to go forward with plans to recognize only the CPT codes for payment of SRS services, deleting the G-codes used to report robotic delivery of SRS.	CMS stated that it received several comments in support of its proposal but some opposing the proposal on the grounds that the direct PE inputs included in the CPT codes do not reflect the typical resource inputs used in furnishing robotic SRS services. These commenters urged CMS to delay the policy change and continue to contractor price the G-codes until a solution can be found. CMS stated that it lacks sufficient information to make a determination about the appropriateness of deleting the G-codes and paying for all SRS/SBRT services using the CPT codes. Therefore, the agency will not delete the G-codes for 2015, but will instead work with stakeholders to identify an alternate approach and reconsider this issue in future rulemaking.
Validating RVUs of Potentially Misvalued Codes			
CMS Contracts with RAND and Urban Institute	In its 2015 MPFS proposed rule, CMS described the current status of outside contracts to help with its Congressionally mandated requirement to validate RVUs. In particular, CMS stated that in its efforts to collect primary data on the time involved in MPFS services, the Urban Institute has encountered numerous challenges. The agency provided an interim report, *Development of a Model for the Valuation of Work Relative Value Units*, which discusses the challenges the Urban Institute has encountered in collecting	Expressed continued concern about CMS contracts with outside entities as part of efforts to comply with a Congressional requirement to validate RVUs. Stated the process has largely been opaque and requested that CMS provide greater transparency, including an opportunity for public comment, prior to the agency adopting any of the outside contractors' recommendations. Based on past activities of the Urban Institute, the AANS and CNS expressed concern about a potential for bias — particular in favor of primary care and against specialty medicine — and asked that CMS be vigilant in providing the specialty physicians that will be affected by these studies a voice in the analysis of data provided by the contractors. A thoughtful and thorough review of the clinical expertise of physicians involved in the "research" conducted by the contractors is essential in establishing creditability for the studies.	CMS acknowledged comments received regarding the Urban Institute and RAND projects, but noted that it did not solicit comments on these projects. CMS stated changes to payment policies under the MPFS that are considered based on the reports would be issued in a proposed rule and subjected to public comment before they would be finalized and implemented.

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	objective time data.		
Neurostim Implantation	CMS reported that a stakeholder raised questions regarding whether the practice expense RVUs for CPT codes 64553 (Percutaneous implantation of neurostimulator electrode array; cranial nerve) and 64555 (Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)) are appropriate when furnished in the nonfacility setting.	Stated that the PE inputs for 64553 and 64555 can be assessed by the RUC without resurveying the RVUs for work	CMS stated its intention to refer 64553 and 64555 to the RUC as potentially misvalued and ask that the codes be surveyed for work as well as PE.
Laminectomy 63045-63048	In the 2014 MPFS Proposed Rule, CMS flagged 63047 and 63048 (lumbar laminectomy) as potentially misvalued and asked that they be surveyed In the 2014 final rule, CMS said the agency would value the codes as interim pending a review of 63045(cervical laminectomy) and 63046 (thoracic laminectomy).	The AANS and CNS presented survey data to the RUC to defend the current value of CPT Codes 63047 and 63048. CMS accepted the RUC passed values as interim for 2014 but asked that CPT Codes 63045 and 63046 also be surveyed. The AANS and CNS conducted a survey and defended the current values for these codes.	CMS received new RUC recommendations for CPT code 63045 and 63046, but did not receive them in time to include in the final rule and they will be considered interim. CMS finalized the work values for CPT codes 63047 and 63048 for CY 2015 with no change in the values.
Improving the Valuation and Coding of the Global Package			
General Issues	CMS proposed to transition all 10-day and 90-day global surgical codes to 0-day global codes.	Strongly opposed eliminating the 10- and 90-day surgical global periods and provided extensive comments supporting its position. Specifically, the AANS and CNS raised the following issues: • **Flaws in the OIG Reports.** Highlighted concerns about the HHS Office of Inspector General (OIG) audits of evaluation and management (E/M) work in the global	Despite receiving many comments in opposition, CMS finalized its proposal to transition and revalue all 10- and 90-day global surgery services to 0-day global periods, beginning with the 10-day global services in CY 2017 and following with the 90-day global services in CY 2018. CMS noted that as it develops implementation details, including revaluations, it would take into consideration all of the comments received to the global surgery proposal, and will provide additional details during the CY 2016 rulemaking. As CMS begins revaluation of services as 0-day globals, it will actively assess whether there is a

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		surgical period, which was cited by CMS as evidence of a problem with global package. The report reviewed a very limited number of specialties and procedures. • **Post-operative work not captured by E/M Codes.** Pointed out that, in addition to visit services, there are many other post-operative care services included in 10- and 90-day global packages including dressing changes, local incision care, removal of operative packs, removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts, and splints, insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, and changes and removal of tracheostomy tubes. • **Practice expense.** The PE for the E/M work in the surgical global package is more resource-intense than separately-reported E/M services. E/M services performed following surgery often include additional, justifiably more expensive, supplies and equipment and may include additional clinical staff time relative to separately-billed E/M services. The RUC thoroughly evaluates the clinical staff time and the typical patient condition and type of services performed when recommending direct PE values. In addition, the indirect PE payment is dependent on specialty and is generally and appropriately higher for surgical specialists and this is reflected in the E/M visits included in the surgical packages. • **Professional liability insurance expense**. The work RVUs of the proxy E/M services contained in the 10- and 90-day global packages are appropriately included in the professional liability insurance (PLI) expense	better construction of a bundled payment for surgical services. CMS stated it will seek the analysis and perspective of all affected stakeholders regarding the best means to revalue these services as 0-day global codes, and urged all stakeholders to engage with agency staff regarding potential means of making the transition as seamless as possible, both for patient care and provider impact. CMS stated it would consider a wide range of approaches to all details of implementation from revaluation to communication and transition, and remains hopeful that sufficient agreement can be reached among stakeholders on important issues such as revaluation of the global services and appropriate coding for post-operative care. CMS stated it is committed to collecting objective data regarding the number of visits typically furnished during post-operative periods and will explore the extant source options presented by commenters as the agency considers other options as well. In an effort to keep specialties from having to duplicate effort, the RUC has put consideration of codes under the "High Expenditure" screen on hold for the January 2015 meeting in order to discuss the process for revaluing the surgical global packages.

calculation because the liability cost of a service should reflect the specialties performing it. Under the CMS proposal to eliminate global periods, E/M work would not be linked to the risk of the original service, would be diluted by the wide mix of all specialties performing E/M, and would not take into account the greater relative risk for the visits of a surgical patient.

- **Office visit level.** On average, global surgical packages have lower levels of office and hospital visits relative to separately-reported E/M visits. The median E/M visit in the global period is 99212, while the median separately-reportable office visit is above a 99213. The same is true for hospital visits. This is a factor that CMS should consider when assessing the impact of any proposal to unbundle visits.

- **Administrative burden**. The CMS proposal to eliminate global periods would create a huge and unnecessary burden for all stakeholders — patients, providers, and payors. Patients would be responsible for paying for each post-op visit separately, disadvantaging those who require more visits. Providers would be subjected to submitting additional claims and the Medicare Administrative Contractors (MACs) would have to process and pay them. In addition, there is no way to know how private payors would choose to treat global periods, creating potential confusion and processing delays.

- **Multiple surgery, bilateral surgery, co-surgeon policies.** Included among the many existing payment structures are those that reduce surgical bundled fees under certain circumstances in which multiple procedures or multiple physicians are involved in the care

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		of the same patient. These policies are in place to account for overlap in resources, including those for E/M services. In addition, modifiers exist to account for a situation in which the post-op care is not provided by the operating surgeon, rarely if ever a situation for a neurosurgical patient. • **RUC review of 10- and 90-day globals.** The RUC has begun to review 10- and 90-day global periods through the Relativity Assessment Workgroup (RAW). Recently, RUC-reviewed codes are clearer in terms of E/M work and we believe the RUC is the appropriate venue to address the valuation of the global surgical package. At the request of CMS, the RUC is in the process of examining high volume and high expenditure codes that have not been previously reviewed. The AANS and CNS stated that this review by the RUC is the most effective method of addressing the issue and that improved education and RUC review of high expenditure codes that have not been previously reviewed will adequately address concerns about the appropriate valuation of global surgical services.	
Proposals for Professional Liability Insurance RVUs			
	CMS reviews, and if necessary, adjusts malpractice (MP) RVUs every five years. For 2015, the agency conducted the third comprehensive review and update of the MP RVUs and proposed new malpractice RVUs for all services based on updated professional liability insurance premiums.	The AANS and CNS provided CMS with the following specific comments on PLI: **Proposed Crosswalk for Neurosurgery PLI update.** Agreed with CMS that use of blended data for neurology (surgical) and neurosurgery seemed reasonable, in the absence of other data. **PLI Five Year Review.** Over the last ten years, the RUC and CMS have replaced the five year review for work and PE RVUs with a process to update	CMS finalized the CY 2015 MP RVU update as proposed with only very minor modifications. For determining the risk factor for certain very low volume services, CMS will override the dominant specialty from it claims data with the and replaced it with the RUC recommended specialty. For all other low volume services, CMS finalized its proposal to use the risk factor of the dominant specialty from its Medicare claims data. CMS also finalized its proposal to combine surgical premiums for neurology and neurosurgery to calculate a national average surgical

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	According to CMS, premium data for neurosurgery were only available from 24 states; therefore the agency did not have sufficient data to calculate a national average premium amount for neurosurgery for purposes of updating the malpractice RVUs. As a proxy, CMS used blended data for neurology (surgical) and neurosurgery, claiming premiums are similar. CMS proposed to use the risk factor of the dominant specialty in determining the PLI RUVs for most services performed fewer than 100 times per year based on the 2013 Medicare claims data. Neurosurgery continues to have the highest risk factor, which is an important element of the RVU calculation and the proposed changes made to malpractice RVUs result in an overall one percent increase in payments to neurosurgeons.	these components on an on-going basis. The RUC has proposed to do the same with PLI RVUs. The AANS and CNS stated its support for this proposal. Updating the PLI RVUs annually would allow the most current PLI premium information to be used, increasing the accuracy and reliability of PLI payments. **PLI Determination for Low Volume Codes.** The issue of valuing PLI RVUs for volume codes has long been a concern for neurosurgery. The AANS and CNS supported the CMS proposal to use the risk factor of the dominant specialty in determining the PLI RUVs for most services performed fewer than 100 times per year based on the 2013 Medicare claims data. However, some codes are so rarely performed or have no Medicare volume for a particular year that the dominant specialty may not accurately reflect the risk. The RUC has asked specialties to review these codes and has provided a list to CMS. The AANS and CNS agree that it is appropriate for the PLI of these codes to be considered on a case by case basis.	premium and risk factor for neurosurgery. In response to comments, CMS stated it would consider the appropriate frequency for collecting new MP premium data and would address potential changes regarding the frequency of MP RVU updates in a future proposed rule. CMS also noted that it would consider suggestions to use multi-year average premiums as it develops a method for updating MP payments for services paid on the anesthesia fee schedule.

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Change in Publication Schedule for Proposed RVUs

CMS received comments from specialty societies and other stakeholders who have experienced reductions in payments as the result of interim final valuations and have objected to the process by which CMS revises or establish values for new, revised, and potentially misvalued codes. These groups stated that they did not receive enough warning about the reductions, causing significant disruption. CMS acknowledged requests that the MPFS proposed RVUs be included in the July MPFS proposed rule, rather than not until the final rule published on or just before November 1 of each year. CMS stated that in order to do so, they would have to have all CPT and RUC changes by January 15, eliminating consideration of codes reviewed at the January or April RUC meetings for the 2016 MPFS	Expressed support for a system under which CMS provides greater transparency and timely notice of its plans to establish or change the values of service in the MPFS and noted that many members of Congress share our views and have raised this issue with the agency. Specifically, AANS and CNS provided the following comments: • **For Calendar year 2016**. Supported the inclusion of as many of the proposed code values as possible in the 2016 MPFS proposed rule published in July 2015, while not disrupting the CPT/RUC schedule. Stated that CMS could review and include a significant number of RUC-reviewed values without imposing a January 15, 2014 deadline for receiving data from the RUC. • **Calendar year 2017 and beyond**. Supported the inclusion of proposed values in the proposed MPFS notices from 2017 and beyond and urged CMS to work with the RUC to establish a timeline that allows physicians earlier notice of changes in valuation. • **G-codes**. Opposed the development of G-codes to use as temporary codes in 2016. This proposal would cause unnecessary confusion and significant additional work. • **Refinement Process.** Supported a continued "appeal" and review process similar to the refinement process	For 2016, CMS will delay implementation of a new process so that those who have requested new codes and modifications in existing codes with the expectation that they would be valued under the MPFS for CY 2016 will not be negatively affected by timing of this change. In the MPFS proposed rule for CY 2016, CMS will propose values for the new, revised and potentially misvalued codes for which it receives the RUC recommendations in time for inclusion in the CY 2016 proposed rule. For those new, revised, and potentially misvalued codes for which it does not receive RUC recommendations in time for inclusion in the proposed rule, CMS anticipates establishing interim final values for them for CY 2016, consistent with the current process. Beginning with valuations for CY 2017, CMS will propose values for the vast majority of new, revised, and potentially misvalued codes and consider public comments before establishing final values for the codes; use G-codes only as necessary in order to facilitate continued payment for certain services for which it does not receive RUC recommendations in time to propose values; and adopt interim final values in the case of wholly new services for which there are no predecessor codes or values and for which CMS does not receive RUC recommendations in time to propose values. CMS has extended the deadline for submission of RUC recommendations to February 10, from its previously proposed deadline of January 15. CMS stated that it would need adequate time to do a thorough job in vetting recommendations and formulating proposals. CMS specifically asked the RUC to assist in minimizing the recommendations that it receives after the beginning of the year, which would also help CMS reduce the instances where it would have to use G-codes for the purpose of holding over current coding and payment policies. Finally, CMS did not finalize its proposal to eliminate the refinement panel. CMS will use the refinement panel for consideration of interim final rates for CY 2015 under the existing rules. CMS will also explore

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			ways to address concerns about the refinement panel process and whether the change to include RVUs in the proposed rule would eliminate the need for a refinement panel.
Medicare Private Contracting/Opt-out			
General Issues	In the MPFS proposed rule, CMS included technical correction for the appeals process relating to opt-out private contracting and clarified that physicians who have validly opted-out of the Medicare program are nevertheless still permitted to write orders and referrals for Medicare beneficiaries.	The AANS and CNS were pleased to see the CMS clarification. Urged CMS to permit physicians to opt-out of the program without the requirement to file an affidavit every two years to remain in an opt-out status. Recommended a policy that would create a safe-harbor period for physicians to remain opted-out of the Medicare program, without penalty or possibility of recoupment, when they have mistakenly not reaffirmed their intention opt-out. The current requirement — that every physician who opts-out of Medicare must re-file an affidavit every two years in order to maintain his or her opt-out status—is overly burdensome.	In the final rule, CMS acknowledged receiving these comments but stated they are outside the scope of this rule as they are not related to the narrow technical proposed changes to the opt-out regulations. Nevertheless, they noted that the statute specifies that the opt-out affidavit must provide that the "physician or practitioner will not submit any claim under this title for any item or service provided to any Medicare beneficiary… during the 2-year period beginning on the date the affidavit is signed." As such, CMS stated that longest interval for which an opt-out can be effective is 2 years and they do not believe the agency has the authority to modify the statutory requirement.
Reports of Payments or Other Transfers of Value to Covered Recipients: Elimination of Open Payment CME Exemption			
General Issues	CMS proposed to eliminate the "bright line" exception for accredited Continuing Medical Education (CME) activities that is currently afforded to physicians through CMS' existing regulations. CMS proposed accounting for "indirect payments" made through third parties as a replacement for the current CME exception. CMS cited it had had requests from additional accrediting bodies to be recognized and the agency said it would did not wish to give the appearance of favoritism among accrediting bodies.	Strongly opposed the elimination of the Open Payments CME exemption. Whether the exemption is duplicative or not, the proposed elimination represents a complete reversal of a policy that was included in the Sunshine Act final rule, which had been thoroughly reviewed and vetted by all stakeholders. Warned that, if the proposal was adopted, it would have a chilling effect on *appropriate* and *vital* industry support of CME, and would expose physicians and physician organizations to additional unnecessary administrative hassles associated with the Open Payments reporting and verification system. Endorsed comments of the Council of Medical Specialty Societies (CMSS) and specifically highlighted several issues: • **Accrediting Organizations.** CMS could easily review requests from additional	After consideration of all comments received, CMS finalized its proposal to eliminate the exemption from Open Payment reporting for accredited CME. CMS stated that manufacturers reporting compensation paid to physician speakers may opt to distinguish if the payment was provided at an accredited or certified continuing education program versus an unaccredited or non-certified continuing education program. CMS clarified that if an applicable manufacturer providing an indirect payment through a continuing education organization and learning the identity of the physician covered recipient in the allotted timeframe (that is, during the reporting year or by the end of the second quarter of the following reporting year) the indirect payment would not meet the criteria of the indirect payment exclusion and would need to be reported. However, payments or other transfers of value, including payments made to physician covered recipients for purposes of attending or speaking at continuing education events, which do not meet the definition of an indirect payment are not

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		accrediting groups and this would in no way imply an endorsement by the agency. Such is the case in other instances where Medicare recognizes the organizations who set standards for various health care stakeholders, including the Joint Commission (hospitals), state medical licensing boards (physicians) and the Accreditation Council for Graduate Medical Education (residency training programs • **Duplicative policy.** Stated that that the fact that other provisions in the Open Payments policy (i.e., indirect benefit policy) may recognize that CME payments are exempt from reporting is not a reason to scrap the CME exemption. Furthermore, it is not clear that such policies will appropriately exempt industry from its reporting requirements given the way accredited CME programs are developed and marketed. CME programs are planned and promoted months, and sometimes years, in advance. Many CME programs are planned and promoted to their intended audiences far enough in advance that attainment of commercial support grants by the CME provider is incomplete. Moreover, as faculty are selected and identified during the activity planning process by the accredited CME provider, their names are promoted in the activity programing to the intended audience. It is not realistic, nor would it be perceived as transparent, if faculty names were hidden until the day of the program, nor would physicians attend such programs. As a result, over time during the planning process, even if the	reportable. For example, if an applicable manufacturer provides funding to support a continuing education event but does not require, instruct, direct, or otherwise cause the continuing education event provider to provide the payment or other transfer or value in whole or in part to a covered recipient, the applicable manufacturer or applicable GPO is not required to report the payment or other transfer of value. The payment is not reportable regardless if the applicable manufacturer or applicable GPO learns the identity of the covered recipient during the reporting year or by the end of the second quarter of the following reporting year because the payment or other transfer of value did not meet the definition of an indirect payment. CMS also noted that it intends for physician speaker compensation and physician attendee fees which have been subsidized through the continuing medical education organization by an applicable manufacturer to be reported unless the payment meets the indirect payment exclusion. CMS will provide sub-regulatory guidance specifying tuition fees provided to physician attendees that have been generally subsidized at continuing education events by manufacturers are not expected to be reported. CMS also agreed with commenters that manufacturers might need additional time to comply with reporting requirements; therefore, it finalized its data collection requirements effective January 1, 2016. In addition, CMS finalized with modification its proposal to require reporting of the marketed name for devices and medical supplies. Specifically, CMS finalized its proposal that reporting marketed names for non-covered drugs, devices, biologicals, or medical supplies will continue to be optional. It also finalized its proposal that manufacturers will continue to have an option to report either a device or medical supply marketed name, therapeutic area or product category when reporting research payments. Also, CMS will require manufacturers to report marketed name and therapeutic area or product category for all covered drugs, devices, biologicals or medical supplies, with data collection for this reporting requirement beginning January 1, 2016.

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		company does not request faculty names, companies providing commercial support to CME providers will potentially learn the names of the faculty, usually before the program, and certainly within two quarters after the program, through promotion of the program itself. The current bright-line rule exempting industry support of certain CME programs from the Open Payments reporting requirements is well understood and more appropriate, regardless of the fact that CMS views this exemption as unnecessarily duplicative. • **Compliance/Administrative burdens.** Emphasized that physicians, physician specialty societies and industry have been operating under the current CME exemption for well over a year. Thus, it is unreasonable for CMS to change the rules without adequate advanced notice to physicians and those groups planning and providing accredited CME. Requested that, at a minimum, a change in the CME policy should be delayed until organizations and CMS can fully analyze the impact of the proposal to eliminate the current exemption. Furthermore, changing the policy will likely subject more physicians to the industry reporting requirements. This additional reporting and verification burden is unnecessary and will not result in any material benefit to patients.	Finally, CMS will require applicable manufacturers to report stock, stock options or any other ownership interest form of payment or other transfer of value in distinct categories.
Physician Compare			
Improvements	CMS reviewed recent improvements made to the	Ongoing improvements to the website and underlying database will be critical as CMS begins	CMS reiterated its ongoing commitment to working with professional societies and the public to ensure the accuracy and utility of the

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to the Website	Website and noted its commitment to making regular updates based on stakeholder feedback.	to report on physicians performance. CMS must first evaluate carefully to what extent patients and physicians are visiting the Physician Compare website and using the information for healthcare decision-making. CMS also must work with the physician community to ensure data is accurate, meaningful and actionable. Requested that the site clarify the inapplicability of the GPRO Web Interface, which relies on a set of primary care-focused measures, to specialty practices. Specialists shouldn't be viewed negatively for not being able to report via this mechanism.	Website for both physicians and patients. All measures slated for public reporting, including QCDR measures, will be consumer tested to ensure they are accurately understood prior to publication. CMS provided few details on this process, but noted it regularly tests the information currently on the website with site users and is planning concept testing of the measures being finalized in this rule prior to publication in 2016. CMS acknowledged concerns about the limitations of PQRS measures, including the limited applicability of some measures to specialties, and how the resultant absence of data may confuse consumers. CMS also understands that disclaimers and other types of explanatory language are necessary to help inform health care consumers as they use the Website. It will continue to work to ensure that language on the site addresses concerns raised and helps users understand that there are a number of reasons a physician may not have quality data on the website.
Timeline	Proposed to move up the date by which it would publicly report on 20 PQRS individual measures collected through a registry, EHR, or claims from late 2015 to early 2015 and to report on 2013 data rather than 2014. Proposed making all individual PQRS measures collected through a registry, EHR, or claims in 2015 available for public reporting in 2016.	Opposed the aggressive timeline, which is insufficient to evaluate the accuracy, relevancy, and meaningfulness of publicly reported group practice data and to apply lessons learned to individual level data. CMS should first carefully evaluate the accuracy and utility of publicly reporting data on larger practices before moving to individual physicians. Inaccurate presentations of such data can lead to serious unintended consequences for both patients and physicians. .	CMS reiterated a previously finalized policy to report in late 2015 on all measures reported via the GPRO Web Interface, 13 EHR, and 16 registry GPRO measures reported by group practices of 2 or more EPs in 2014. CMS also will make available all Shared Savings Program ACO measures. Due to concerns about the timeline and the fact that physicians were unaware at the time of data collection that these performance rates would be published, CMS did NOT finalize the proposal to move up the date of publicly reporting on 20 select individual measures. However, CMS did finalize its proposal to publicly report ALL 2015 PQRS individual measures collected via registry, EHR, or claims in late 2016, if technically feasible. To ease concerns about accuracy/utility, CMS also clarified that prior to public reporting, all measures, including QCDR measures, must: meet a minimum sample size of 20 patients; must prove to be statistically valid, reliable, comparable, and accurate (data will be analyzed and reviewed by CMS' Technical Expert Panel); will be tested on consumers; and that no first year measures will be publicly reported. All measures that meet these requirements will available to the public

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			in a Physician Compare downloadable file. However, not all measures will be included on physician profile pages. CMS' analysis of the collected measure data, along with consumer testing and stakeholder feedback, will determine specifically which measures are published on profile pages on the website.
Preview Period	Proposed to provide a 30-day preview period.	Physicians should be given at least 60 days to review and offer corrections to their data before it is published.	Physicians will be given 30 days to preview performance data. If an error is found in the measure display during this preview period, they can contact the Physician Compare team by phone/e-mail to have concerns addressed. Errors will be corrected prior to publication. To date, CMS noted that has found the 30-day preview period to be sufficient despite requests to lengthen this period.
Benchmarking	Proposed to use benchmarks in 2016 for 2015 PQRS GPRO data reported on Physician Compare, using the same methodology currently used under the Medicare Shared Savings Program.	Urged CMS to use consistent benchmarking across its programs to minimize confusion/complexity. We opposed arbitrary thresholds, such as star ratings, which may result in inappropriate distinctions between physicians whose performance is not statistically different. Urged CMS to recognize personal improvement rather than the attainment of benchmarks.	Acknowledged neurosurgery's concerns and decided not to finalize this proposal at this time. CMS wants to be sure to discuss more thoroughly potential benchmarking methodologies with stakeholders prior to finalizing this proposal. CMS also wants to evaluate other programs' methodologies, including the value-modifier, to work toward better alignment across programs.
Specialty Society Measures	CMS solicited comments on including specialty society measures on Physician Compare or linking Physician Compare to specialty society Websites that publish non-PQRS measures.	Supported giving specialty societies the option to publicly report their measures via their own Websites linked to Physician Compare so long as the measures are grounded in evidence, developed by relevant clinical experts, and have been adequately vetted. Warned that this policy shouldn't extend to measures developed by private payers or other stakeholders for which the level of physician involvement is unclear. Also urged CMS to include a disclaimer on the site regarding the limitations of the PQRS measure set and how specialty-selected measures may offer patients more relevant and meaningful information.	CMS acknowledged widespread support for including specialty society measures, as well as all of neurosurgery's caveats. CMS did not finalize anything related to this proposal, but appreciates this feedback and will consider it in future rulemaking.
QCDR Data	Proposed to require the reporting of individual EP-level 2015 QCDR measures starting in 2016. Data would have to be reported	Supports the flexibility CMS would give QCDRs to select the appropriate reporting format/strategy. Aggregate reporting, in particular, will help ensure that physicians who are low volume providers are not unfairly penalized under this	Despite claiming to understand timeline and other concerns, CMS finalized its proposal to publicly report individual physician-level 2015 QCDR measures data in 2016. CMS feels it gave QCDRs ample notice that this requirement was coming. The final policy includes some modifications, noted below:

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	by April 30 following the reporting year. QCDRs could report the data in the format of their choosing and select whether to report data on Physician Compare or via a link to their own website. Clarified that QCDRs would only be required to publicly report on data related to measures reported for purposes of PQRS.	reporting mechanism. Voiced concern over the April 30 timeline given the time needed to ensure data is meaningful and accurate, especially for newer registries that need to collect data over time to define appropriate benchmarks. As an alternative, supported a more scaled approach that establishes criteria for moving toward accurate and meaningful public reporting of QCDR performance information over time and with experience.	• Recognizing that physicians should be afforded the opportunity to simply learn from first year data and not have this information shared publicly until the measure can be vetted for accuracy, CMS will NOT require the public reporting of first year QCDR measures. This policy also applies to traditional PQRS measures and is consistent with the Value Modifier policy. If a QCDR first reports on a non-PQRS measure that is already being reported by another QCDR, CMS would consider the measure in its first year of reporting for that respective QCDR. • As originally discussed, in order to recognize the burden/time/resources that public reporting measures data could pose to QCDRs, CMS will defer to the entity in terms of the format it will use to publicly report the quality measures data it collects for the PQRS (e.g., individual vs. aggregate level). QCDRs may also choose where to report their performance rates (e.g., through a board or specialty website, listserv dashboards or other announcement). However, to address concerns regarding the lack of time for QCDRs to establish user-friendly websites for sharing data as well as concerns about data consistency, CMS will NOT require reporting on a QCDR website. However, all QCDR data will be available via Physician Compare (i.e., QCDRs are free to provide this information elsewhere, but Physician Compare website will serve as a point where all information will be accessible). • QCDR data will only be publicly reported on Physician Compare at the individual-EP level. Despite commenters' support for group-level data, CMS feels that QCDR data are not necessarily aggregated to a level consistent with how PQRS defines a group practice and aggregated data cannot be accommodated on Physician Compare at this time. • CMS will review all QCDR data prior to public reporting to ensure that the measures included meet the same standards as the PQRS measures being publicly reported (e.g., 20 patient sample size, valid, reliable, etc.). • Although CMS feels the April 30 following the reporting year is

TOPIC	PROPOSAL	AANS/CNS COMMENT	OUTCOME
			reasonable, due to public concerns about accuracy and reliability, CMS decided to extend the deadline by which QCDRs must publicly report quality measures data outside of Physician Compare (if they so choose) to the deadline by which Physician Compare posts QCDR quality measures data. *Note: Other commenters requested NQF endorsement for all QCDR measures, and one commenter suggested that CMS develop rules and guidelines for measure stewards who develop non-PQRS measures housed in QCDRs*.
CAHPS Measures	Proposed to publicly report 2015 *CAHPS for PQRS* survey data for group practices of 2 or more EPs who report this data, as well as CAHPS for ACOs	Opposed public reporting of CAHPS or other patient experience survey data due to the subjectivity of these surveys, potential perverse incentives to keep the patient satisfied, and the cost of administering the surveys	Finalized this decision despite acknowledging concerns about the subjectivity and the cost of administering these measures. CMS is confident that CAHPS is a well-tested collection mechanism that produces valid and comparable measures of physician quality based on the extensive testing and work that has been done by AHRQ and the CAHPS Consortium.
Composite Scores	Solicited comments on creating composites using 2015 data and publishing composite scores in 2016 by grouping measures based on the PQRS GPRO measure groups, if technically feasible.	Opposed publicly reporting composite scores until CMS has further studied the accuracy and relevance of calculating composites.	CMS acknowledged both positive and negative comments on this topic, but did not finalize any decisions related to publicly reporting composite measures at this time.

Physician Quality Reporting System (PQRS)

Penalties	Under statute, the PQRS incentive payment goes away in 2015 and CMS must apply a 2% penalty to all physicians in 2017 that do not satisfy 2015 PQRS reporting requirements.	Opposed holding physicians to such high reporting standards (see below) in the first year the PQRS transitions to all penalties, especially since many physicians still have not yet participated in the program due to a lack of relevant/meaningful measures.	As noted, the 2% penalty is a statutory requirement. Recognizing concerns about the high reporting bar in light of penalties, CMS made modifications to its cross-cutting measure proposal and a few other aspects of PQRS, as discussed below, but will continue to require 9 measures across 3 domains for 50% of applicable Medicare Part B patients when reporting individual measures. Despite CMS' desire to phase out claims-based reporting, it will preserve this mechanism for the 2015 reporting year, recognizing that this is the only option for some physicians. It also remains the most popular reporting option, even though other reporting mechanisms have seen greater reporting success.
Removal of Measures	Proposed to remove over 70 measures for 2015, including the Perioperative	Opposed removal of these measures, especially when 2015 is the first year that the PQRS will transition to an all-penalty program and in light of	CMS ultimately added 20 new individual measures and two measures groups to fill existing measure gaps, and removed 50 measures 6

TOPIC	PROPOSAL	AANS/CNS COMMENT	OUTCOME
	Measures Group, the Back Pain Measures Group, Ischemic Vascular Disease Measures Group, and multiple individual measures related to stroke, Parkinson's. CMS claimed many of these measures were "topped-out" and/or represented a basic standard of care that did not add clinical value to PQRS at this time.	the increasingly difficult reporting requirements. Leaves neurosurgeons with very few, if any, relevant measures to report on and will result in reporting non-meaningful measures simply to satisfy reporting requirements. The elimination of the Perioperative Measures Group is particularly concerning since this is the only set of current PQRS measures that applies broadly across the various neurosurgical subspecialties and has been woven into the N2QOD. At the very least, measures should be phased-out, and specialties given at least a two-year grace period over which they can seek alternative reporting mechanisms. Requested at least a two-year grace period during which measures proposed for removal could remain in the program while physicians identify alternative reporting mechanisms/specialties develop more measures. In regards to "topped-out" measures, noted that informing the public about high performance across-the-board is not necessarily a bad thing and criticized quality programs for focusing only on the bad seeds. Also questioned how CMS would know if performance subsequently declined after removal of a "topped-out" measure.	measures groups, for a total of 255 individual measures. **<u>Removal of Measures for 2015</u>** Retired **measures groups** that may have been reportable in the past by neurosurgeons include: • Perioperative Care Measures Group • Back Pain Measures Group • Ischemic Vascular Disease Measures Group * *Note: the only remaining measures group that may apply to select neurosurgeons in 2015 is the Parkinson's Measures Group.* Retired **individual measures** that may have been reportable in the past by neurosurgeons include: • Perioperative Care: Timing of Prophylactic Parenteral Antibiotic –Ordering Physician • Perioperative Care: Timing of Prophylactic Antibiotic—Administering Physician • Stroke and Stroke Rehabilitation: VTE Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage • Stroke and Stroke Rehabilitation: Screening for Dysphagia • Stroke and Stroke Rehabilitation: Rehabilitation Services Ordered Osteoarthritis: Assessment for Use of Anti-Inflammatory or Analgesic OTC Medications • Epilepsy: Seizure Type(s) and Current Seizure Frequency • Epilepsy: Documentation of Etiology of Epilepsy or Epilepsy Syndrome However, CMS did recognize and agree with neurosurgery's comments that some of its original proposals could negatively impact a surgeon's ability to satisfy PQRS. As such, it **CMS changed course and decided to maintain the following measure**s, originally slated for removal, as individually reportable measures: • Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin • Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures) • Perioperative Care: VTE Prophylaxis • Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy

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			• Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge • Osteoarthritis: Function and Pain Assessment CMS warns that while it is preserving these measures for 2015, it continues to look for better outcome measures and that these measures may be considered for removal in the future. **Newly Added Measures for 2015** CMS did not add any new measures for 2015 that are relevant to neurosurgery. The one potentially relevant measure proposed for addition in 2015 was Average Change in Functional Status Following Lumbar Spine Fusion Surgery. However, CMS decided not to finalize it due to concerns that the measure has not been fully vetted/tested, remaining analytic implementation challenges, and a the lack of a performance target to assess the measure against. **Domain Changes for 2015** CMS also finalized domain changes for certain measures that a neurosurgeon may report, including those related to: medication reconciliation, carotid endarterectomy, and Parkinson's. This could have implications in terms of satisfying the requirement that reported measures cross 3 domains. CMS noted its commitment to expanding the specialty measures available in PQRS in order to more accurately measure the performance on quality of care furnished by specialists. CMS also pointed to the QCDR and group reporting options to ameliorate commenters' concerns that the current set of PQRS measures does not capture all of the clinical care that some specialists and sub-specialists furnish. CMS also continues to work with specialty societies to group PQRS measures according to specialty, simply as a guiding tool, but not a requirement.
Reporting Requirements	Proposed to maintain individual measure reporting requirement for claims and qualified registry reporting that physicians	Urged CMS to lessen the reporting burden in the first year that the program transitions to all penalties, especially in light of the dwindling number of relevant measures for specialty medicine and the increasingly high bar for QCDRs.	Despite widespread opposition to these proposed requirements, CMS finalized the requirement that physicians reporting individual measures via claims or registry must report 9 measures across 3 domains for 50% of applicable Medicare Part B FFS patients. CMS feels it provided the public with adequate time to prepare for this requirement and noted

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	report on 9 measures covering three National Quality Strategy (NQS) domains for at least 50% of applicable Medicare Part B patients. Also proposed that two of those measures come from a list of 18 "cross-cutting" measures.	Opposed requiring the reporting of "cross-cutting' measures. Disappointed that this policy emphasizes a core set of measures that are primary care-focused rather than furthering the goal of offering physicians enhanced flexibility to select measures most relevant to their practice.	its intent to ramp up the reporting criteria in previous rules. Partially recognizing neurosurgery's concerns about cross-cutting measures reporting burden, CMS decided to only require the reporting of 1 cross-cutting measure. However, CMS made no improvements to the set to better reflect specialty care. In fact, it finalized the proposed set and added an additional primary care-focused measure (Diabetes: Hemoglobin A1c Poor Control) for a total set of 19 cross-cutting measures available for reporting. CMS also highlighted that the cross-cutting measure requirement does not apply to QCDRs. In response to concerns about a lack of specialty measures, CMS reminded the public that physicians who report less than 9 measures via claims or qualified registry (or do not report on a cross-cutting measures) can still avoid the PQRS penalty, but will be subject to the Measure-Applicability Validation (MAV) process to determine whether he/she reported on as many measures that are applicable his/her practice.
CAHPS	Proposed to require all group practices of 100 or more EPs to report on the CG-Consumer Assessment of Healthcare Provider and Systems (CAHPS) survey for PQRS in addition to reporting traditional PQRS measures. Groups with 2 or more EPs could elect to report these CAHPS measures. All group practices using this option would bear the cost of contracting with a certified vendor to administer the survey.	Due to the subjective nature of these measures and perverse incentives that may result from patient satisfaction measurement, urged CMS to focus on evidence-based, physician-driven clinical quality measures for accountability purposes and to retain patient experience measures for internal quality improvement purposes only.	CMS finalized it proposal to make CG-CAHPS reporting mandatory for groups with 100 or more EPs and optional for smaller groups, as well as requiring that groups of all sizes bear the cost of contracting with a certified survey vendor. In response to concerns, CMS noted its confidence that CAHPS is a well-tested collection mechanism that produces valid and comparable measures of physician quality based on the extensive testing and work done by AHRQ and the CAHPS Consortium. CMS agreed with other commenters on the importance of alternatively allowing the Surgical-CAHPS (S-CAHPS) to be reported under PQRS outside of QCDRs, but noted it is not technically feasible to implement this policy for the 2017 or the 2018 adjustment. However, CMS will permit QCDRs to administer the S-CAHPS as a non-PQRS measure for the 2017 or 2018 PQRS payment adjustments

TOPIC	PROPOSAL	AANS/CNS COMMENT	OUTCOME
Measures Groups Size	Proposed to require that measures groups include at least 6 measures, rather than 4.	Opposed increasing the size of measures groups, especially in light of penalties and increasing reporting requirements. Groups should be defined based on the relevance of measures rather than an arbitrary number of measures.	Finalized decision to define a measures group as a subset of 6 or more PQRS measures that have a particular clinical condition or focus in common. CMS acknowledged neurosurgery's concerns, but noted that it performed clinical analyses to ensure that the added measures were relevant and not arbitrary. CMS noted that some of the measures added to measures groups (e.g., cross-cutting measures such as Smoking Cessation and Medication Reconciliation) may not directly address the specific topic, but are accepted in the clinical community as critical to monitor.
QCDR Requirements	Proposed to require that QCDRs report on 9 measures across 3 domains for 50% of ALL applicable patients (Medicare and non-Medicare), including 3 outcomes measures (or 2 outcomes and 1 of the following: resource use, patient experience or efficiency/appropriate use measure)	Continues to support the concept of the QCDR, which offers specialties that lack a sufficient number of relevant PQRS measures the opportunity to participate in a more meaningful manner. Supported the following policies: • To increase the number of non-PQRS measures that QCDRs can include from 20 to 30; • Extending the deadline by which QCDRs must submit quality measure data to CMS to March 31 of the year following the reporting period; • Permission to use an external organization for data collection/data transmission; • Recognizing entities that have broken off from a larger organization for purposes of QCDR qualification; • Allowing individual specialties to determine their own standards for meaningful risk-adjustment.	CMS finalized requirement to require the reporting of 9 measures across 3 domains for 50% of all applicable patients (both Medicare and non-Medicare) despite opposition among the majority of commenters. In response to concerns that the 50% reporting requirement is an enormous burden, especially for those who see many patients, CMS highlighted the importance of collecting sufficient data to ensure an adequate sample. The 50% requirement helps to prevent selection bias while still being mindful of reporting burden as EPs are still becoming accustomed to reporting. CMS did not address the possibility of sampling patients, even though this is the mechanism used for group practices reporting measures via the GPRO Web Interface. Due to other concerns about the reporting burden, CMS decided to only require the reporting of 2 outcomes measures or if 2 are not available, then 1 outcome measure and 1 of the following types of measures: resource use, patient experience of care, efficiency/appropriate use or patient safety *(note: "patient safety" is a new category that was not included in the proposed rule, but added to provide additional flexibility).* CMS finalized all of the policies that neurosurgery supported, including allowing QCDRs to report up to 30 non-PQRS measures and extending the deadline for submitting quality measure data to March 31. CMS finalized its proposal to require the public reporting of QCDR measures so long as they meet the requirements set out for public reporting all other PQRS measures, which includes NOT publicly

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		Nevertheless, continues to view many requirements as unreasonable and ignoring unique capabilities of different registries, including: • Reporting on 50% of ALL applicable patients, which is more than traditional PQRS requires; requested that CMS permit a statistically valid sample instead. • Reporting on an arbitrary number of measures instead of letting QCDRs which/how many measures most accurately reflect their specialty. • Requiring a standardized PQRS measure format (numerator/denominator/ exclusions); registries don't typically capture variables in this format, which could hinder more robust data capture. • Newly proposed requirements to publicly report and benchmark data Supported a more gradual approach to holding QCDRs to standards that will ensure more accurate and reliable data over time. Urged CMS to clarify current informed consent requirements for registries performing quality improvement activities. Suggested explicit actions federal agencies could take to establish this vital guidance. Urged CMS to make administrative data widely available to registries in order to achieve more accurate analyses of value.	reporting on first year measures. CMS appreciates concerns that QCDR data should not be publicly reported until accurate benchmarks are available, but is moving forward with public reporting of QCDR data since, even without benchmarks, these data can provide consumers with very valuable and instructive information. See section above titled, "Physician Compare," for additional policy decisions related to QCDRs. CMS did not address neurosurgery's comments about informed consent requirements for registries or making administrative data more widely available to registries.

TOPIC	PROPOSAL	AANS/CNS COMMENT	OUTCOME
Physician Value-Based Payment Modifier (VBM)			
General Issues	As required under statute, CMS must apply the VBM to all physicians by 2017. CMS used its discretionary authority to propose to double the VBM penalty to 4% in 2017 for all group practices and solo practitioners.	Strongly opposed CMS' rapid application of penalties, particularly since it will now apply to small practices and solo practitioners and since CMS is proposing to remove so many PQRS measures. This is yet another regulatory requirement that will only compound the burden that practicing physicians already face and potentially put more than 10% of a physician's payments at risk in the coming years. Urged CMS to ease in new participants, smaller practices, and those without relevant measures by either holding them harmless from participation *and* performance-based penalties, reducing the initial payment penalty, or requiring less stringent reporting requirements during the initial year.	In response to neurosurgery's concerns that this proposal is too aggressive and may impact patient access to care, especially in light of the cumulative impact of federal quality reporting penalties, CMS decided to apply a lower penalty of -2% in 2017 to smaller group practices (2-9 EPs) and solo practitioners for failure to satisfy PQRS in 2015. Groups with 10 or more EPs would be subject to a -4% penalty. ALL physicians are subject to quality tiering in 2017. However, CMS decided to hold harmless from downward performance-based payment adjustments in 2017 those groups with 2-9 EPs and solo practitioners. These EPs may only receive a neutral or upward performance-based payment adjustment (up to +2x) Larger practices (10 or more EPs) may receive downward (up to -4%), neutral, or upward (up to +4x) performance-based payment adjustments in 2017. CMS noted efforts to collaborate with medical specialty societies to expand their outreach and education on the VBM.
Quality Measures	Proposed to continue to base VBM largely on PQRS measures, and other previously finalized acute and chronic care readmission composite measures. Does not yet have technical capacity to use QCDR data for VBM quality calculations so instead would automatically deem physicians who satisfactorily report to a QCDR as "average" quality for purposes of the VBM calculation.	Ongoing concern about lack of relevant PQRS measures, especially in light of proposal to remove many measures. Urged CMS to adopt a mechanism to use QCDR data for both quality and cost calculations under the VBM. Suggests a 2-year grace period where QCDRs can collect/refine/benchmark data. During this time, they'd be held harmless from VBM performance-based penalties rather than being classified as "average" quality, which could result in a downward adjustment if costs are calculated as "high." Appreciates proposal to make reporting of CAHPS measures in 2015 for purposes of the 2017 VBM optional for groups with two or more.	For 2017, the VBM quality calculation will be based on: • PQRS measures reported through any mechanism (except new measures, which do not yet have benchmarks); - Additional, previously finalized, claims-based outcomes measures that CMS will automatically calculate: - A composite of rates of potentially preventable hospital admissions for heart failure, chronic obstructive pulmonary disease, and diabetes; - A composite rate of potentially preventable hospital admissions for dehydration, urinary tract infections, and bacterial pneumonia; and - Rates of an all-cause hospital readmissions measure • Groups with 2 or more EPs also will be able to elect to have patient experience of care measures collected through the 2015 CAHPS for PQRS survey included in their quality of care composite. CMS maintained its proposal that, beginning with the 2014

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			performance period, measures reported through a QCDR that are new to PQRS (first-year measures) will not be included in the quality composite for the VBM until such time as CMS has historical data to calculate benchmarks for them. Once CMS has historical data from measures submitted via QCDRs, the benchmark will be the national mean for the measure's performance rate during the year prior to the performance period. For the 2017 VBM, in cases where groups are assessed under the "50% option" (i.e., when CMS looks to see if at least 50% of individual physicians in a group practice participated in PQRS in cases where the group as a whole doesn't elect participate in GPRO) and all EPs report via QCDR in 2015, but CMS is unable to receive quality performance data, then it will classify the group's quality composite score as ''average'' under the quality-tiering methodology. For groups assessed under the "50% option" where some EPs in the group report data using a QCDR and CMS is unable to obtain the data, but others in the group report using another PQRS reporting mechanism, CMS will calculate the group's score based on the reported performance data it obtains through those other mechanisms.
Cost Measures	Would continue to rely on Total Per Capita Cost measures and the Medicare Spending Per Beneficiary (MSPB) measure.	Opposed CMS' decision to not apply socioeconomic status (SES) adjustments to cost measures under the VBM. Ongoing concerns about CMS' continued reliance on broad-based cost measures (such as Total Per Capita Cost measures and the Medicare Spending Per Beneficiary (MSPB) measure), which assess the total amount billed per patient and not the cost of the specific care provided by the individual physician Encouraged CMS to move toward more episode-specific cost measures and to continue to consult specialties throughout development process.	Despite ongoing concerns raised, CMS will continue to rely on the Total Per Capita Cost measures and the MSPB measure since more specific episode-based cost measures are not yet available. CMS acknowledged support for SES adjustments, but wishes to defer on the issue until after the NQF has finalized its guidance on this topic. CMS feels it's important to proceed cautiously on this topic and will continue to monitor NQF activities. Minor modifications were made to the attribution methodology. CMS reversed the current exclusion of certain part-year Medicare beneficiaries in the 5 Total per Capita cost measures to include Medicare FFS beneficiaries who are at the end of life in the performance period and those who are newly enrolled in Medicare during the performance period and enrolled in both Part A and Part B while in Medicare FFS. CMS also made changes to allow for more consideration of primary care services furnished by non-physician EPs. These changes will apply to the 5 Total per Capita cost measures and the 3 claims-based quality

TOPIC	PROPOSAL	AANS/CNS COMMENT	OUTCOME
			measures starting with the 2017 payment adjustment. Groups and solo practitioners will continue to receive a cost composite score that is classified as ''average'' under the quality-tiering methodology if the group or solo practitioner does not have at least one cost measure with at least 20 cases.
Data Review/ Informal Inquiry	Proposed a more formal process for groups to request a correction of a perceived error. <u>2015 adjustment</u> Would re-compute cost composite/readjust performance tier in cases of an error. But not technically feasible to do same for quality calculation errors so would instead classify group as "average quality." Would give groups until at least February 2015 to request a correction for the 2015 payment adjustment. <u>2016/2017 adjustment</u> Would be able to re-compute quality composite in case of error. Would establish a 30-day period that would start after the release of the QRURs for a physician to request a correction of a perceived error.	For 2015 adjustment, supported a February 2015 deadline since it provides more time to physicians and aligns with PQRS process, but concerned about classifying physicians as "average" quality given associated penalties. For 2016/2017, urged CMS to instead adopt a 60-day period for physicians to request a correction given complexity of the calculations and difficulty accessing QRURs.	Persuaded by neurosurgery's concerns about the brevity of the proposed 30-day process, CMS finalized a deadline submission for requesting a VBM informal review of February 28, 2015 for the 2015 payment adjustment period. This also is consistent with the PQRS informal review process. Beginning with the 2016 payment adjustment year, CMS also finalized a 60-, rather than 30-, day period following the release of QRURs for an EP to request a correction of a perceived error. For the 2015 payment adjustment, CMS will recalculate the groups' cost composite if it finds an error was made. CMS recognized concerns about automatically classifying groups as "average quality" and is working to develop a process for correcting quality measure errors in the future. However, if this operational infrastructure is not available, CMS will continue the approach for the 2015 payment adjustment period to classify a group as ''average quality'' in the event an error in the calculation of the quality composite is identified. Starting with the 2016 payment adjustment period, CMS will adjust a group's quality-tier if it makes a correction to a TIN's quality and/or cost composites as a result of this process.

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