CY 2015 Outpatient Prospective Payment System (OPPS) and CY 2015 Medicare Physician Fee Schedule (PFS) Proposed Rules

--Medical Leaders Interest Group Outreach--

The Centers for Medicare & Medicaid Services (CMS) recently released the calendar year (CY) 2015 Outpatient Prospective Payment System (OPPS) and the CY 2015 Medicare Physician Fee Schedule (PFS) proposed rules. These rules include proposed changes to the following policies and programs:

- Payment for device-dependent services under new Comprehensive Ambulatory Payment Classifications (C-APCs)
- Hospital Outpatient Quality Reporting Program
- Quality Performance Standards for the Medicare Shared Savings Program

As America's Essential Hospitals works on its comments, we want to hear from our members so that our comments reflect your concerns. Specifically, we are seeking input on the questions below.

We thank you in advance for your time.

Comprehensive Ambulatory Payment Classifications (C-APCs):

1. *C-APCs.* CMS proposes to implement its CY 2014 proposal to pay for device-dependent services using C-APCs. The C-APCs would package all services related to the primary device-dependent service into one prospective payment amount. The C-APC payment amount is based on the cost of the primary service and all of the adjunctive services provided in support of the primary service. Adjunctive services are those services that are provided during the delivery of the comprehensive services, such as lab tests or supplies. CMS will assign a new status indicator, "J1," that would be assigned to the healthcare common procedure coding system (HCPCS) codes for a comprehensive service. Any time a J1 procedure is on a claim for Medicare outpatient payment, CMS would pay the hospital a single C-APC payment for the primary service and all adjunctive services. In this rule, CMS is proposing to reconfigure and restructure the C-APCs that were finalized last year, as well as add other device-dependent services to the list of C-APCs, resulting in a total of 28 C-APCs for CY 2015.

   Most types of adjunctive services payable under the OPPS would be packaged into a C-APC when provided in conjunction with the device-dependent primary services. These adjunctive services that would be packaged into the C-APC include diagnostic procedures, lab tests and diagnostic tests that assist in the delivery of the primary procedure, visits and evaluations associated with the primary procedure, durable medical equipment provided as part of the outpatient service, and HOPD services similar to therapy that are delivered as part of the comprehensive service by therapists or non-therapists. Payment for drugs, biologicals, and radiopharmaceuticals, would also be packaged, except for drugs with pass-through status and self-administered drugs (SADs). In addition to SADs, recurring therapy services, ambulance services, diagnostic and screening mammography, annual wellness visits, pass-

through devices, and preventive services will continue to be paid separately from the C-APC payment.

Questions regarding CMS' C-APCs proposal:

a) Are there certain types of services that CMS proposes to package with the device-dependent service (listed above) that are provided with greater frequency at your hospital (compared to other hospitals, due to your unique case mix and patient characteristics)?
b) Do the C-APC packaging proposals appropriately take into account the range of different services that are provided at your hospital in conjunction with the primary service?
c) From a clinical perspective, are the types of services being packaged those that are typically provided in association with the primary device-dependent services?

2. *C-APC complexity adjustment*: To account for complex cases when a primary JI procedure appears on a claim with certain other procedures, CMS will apply a complexity adjustment. When certain combinations of two JI procedures are on a claim, or combinations of J1 procedures and certain add-on codes are on a claim, CMS will pay the hospital the next-highest C-APC amount in the clinical family. CMS has identified the 52 different higher-cost procedure combinations to which it will apply a complexity adjustment. CMS identifies combinations that qualify for a complexity adjustment using the following two criteria:

- Frequency threshold: Frequency of 25 or more claims reporting the code combination; and
- Cost threshold: the comprehensive geometric mean cost of the complex code combination exceeds the comprehensive geometric mean cost of the lowest significant HCPCPS code assigned to the C-APC.

Questions regarding CMS' proposal for a C-APC complexity adjustment:

a) Are the proposed complexity adjustments the types of procedure combinations that are more complex and require more resources in your hospital?
b) What other outpatient device-dependent procedures or combinations of procedures require more resources at your hospital?
c) What criteria should be used to determine when to adjust a case involving a device-dependent procedure for complexity?

Other Packaging Proposals:

3. Apart from the C-APCs proposal, CMS also proposes to package all ancillary services with a geometric mean cost of less than or equal to $100 with the primary service. These ancillary services would mainly be minor diagnostic tests and procedures usually performed in conjunction with a primary service. Ancillary services that would not be packaged include certain preventive services.

Question regarding CMS' proposal to package ancillary services:

a) Are there types of ancillary services that are provided alone (not in conjunction with a primary service) or that should not be packaged with the primary service regardless of how much they cost?

Hospital Outpatient Quality Reporting (OQR) Program:

In the proposed rule, CMS proposes to add one measure to the OQR Program, remove three measures, and exclude one measure and change it to voluntary reporting.

4. For the CY 2017 payment determination, CMS proposes to add one claims-based measure: OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (this includes all-cause, unplanned hospital visits, such as ED visits, observation stays, and inpatient admissions).

   Questions regarding the proposed changes to the OQR measures:

   a) Is the colonoscopy measure the right measure to focus on in terms of what constitutes high-quality care and clinical practice in the hospital outpatient department?
   b) If a colonoscopy is done well, what would you expect to see in terms of resulting hospital visits? What if the colonoscopy is not performed properly?
   c) Are hospital visits within 7 days of the procedure the right way to assess how well a colonoscopy is performed?
   d) Does this measure provide useful information on hospital quality in the outpatient setting?
   e) Would your hospital anticipate any issues with collecting and reporting data for this measure?

5. CMS proposes to remove three topped-out measures beginning with the CY 2017 payment determination:
   - OP-4: Aspirin at Arrival (NQF # 0286) (chart-abstracted)
   - OP-6: Timing of Antibiotic Prophylaxis (chart-abstracted)
   - OP-7: Prophylactic Antibiotic Selection for Surgical Patients (NQF # 0528) (chart-abstracted)

   CMS also proposes to exclude the OP-31 measure (Cataracts - Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (NQF #1536)) from the CY 2016 payment determination and to change the measure from required to voluntary reporting beginning with CY 2017.

   Questions regarding the removal of measures:

   a) Do you have any concerns with the removal of these measures?

CY 2015 PFS Proposed Rule – Medicare Shared Savings Program (MSSP)

6. CMS proposes to add the following 12 measures to the MSSP's quality performance standards:

Proposed Measures for Inclusion in Quality Performance Measure Set	**NQF endorsed?**	**Replacing Existing Measure?**	**Additional Notes about Measure**
CAHPS Stewardship of Patient Resources	Yes	No	Survey measure, already collected but not scored; proposed to be a scored measure in the patient experience domain
SNF 30-day All-Cause Readmission Measure	**No – under review (NQF #2510)**	No	Claims based measure
All-Cause Unplanned Admissions for Patients with Diabetes Mellitus (DM), Heart Failure (HF) and Multiple Chronic Conditions	**No - under development by Yale New Haven Health Services Corporation/CORE**	No	Proposed to be added to Care Coordination/Patient Safety domain
Depression Remission at Twelve Months	Yes (NQF#0710)	No	Submission through GPRO
Diabetes Measures for Foot Exam and Eye Exam	Yes (NQF #0055 and #0056)	No	Proposed to be added to the Diabetes Composite Measure (Clinical Care for at Risk Population-Diabetes); measures would align with PQRS and EHR Incentive Program
Coronary Artery Disease (CAD): Symptom Management	Yes	No	Proposed to be added to the CAD Composite Measure (Clinical Care for At Risk Population-Coronary Artery Disease (CAD) domain; measure would align with PQRS (PQRS #0242) and the EHR Incentive Program
Coronary Artery Disease (CAD): Beta Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF<40%)	Yes (NQF #0070)	No	Proposed to be added to the CAD Composite Measure

Coronary Artery Disease (CAD): Antiplatelet Therapy	Yes (NQF #0067)	Yes - measure would replace the existing measure ACO #30, Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic, which CMS is proposing to remove because it no longer reflects current clinical guidelines	Would be added to the Clinical Care for At Risk Population-Coronary Artery Disease domain and included in the CAD Composite Measure
Documentation of Current Medications in the Medical Record	Yes (NQF #0419)	Yes - measure would replace ACO #12 (NQF #0097) Medication Reconciliation measure	Measure aligns with both PQRS and the EHR Incentive Program
Percent of PCPs who Successfully Meet Meaningful Use Requirements	Yes	Yes - modifies the name and specifications for ACO #11 Percent of PCPs who Successfully Qualify for an EHR Incentive Program Payment, so that it more accurately depicts successful use and adoption of EHR technology in the coming years	Would continue to be doubly weighted

As you can see in the table above, some of the measures are not NQF endorsed or still under development at this point. All 37 measures would be phased in for ACOs with 2015 start dates according to a phase-in schedule - ACOs with start dates before 2015 would be responsible only for complete and accurate reporting of the new measures for the 2015 performance year, and then responsible for either reporting or performance on the measures according to the phase in schedule.

<u>Questions regarding the proposed new measures used for establishing quality performance standards for the MSSP:</u>

a) Some measures are being proposed to replace existing measures:
   - Coronary Artery Disease (CAD): Antiplatelet Therapy (NQF #0067) would replace ACO #30, Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
   - Documentation of Current Medications in the Medical Record (NQF #0097) would replace ACO #12 (NQF #0097) Medication Reconciliation measure

   In these instances, are the proposed new measures an improvement over the current measure?

b) Do the proposed measures represent the right focus for the MSSP?
c) Is there anything about the collection and reporting of these measures that should be highlighted for CMS?
d) Are there any issues with the measures already included in the existing program?
e) For the measures taken from surveys, do you have any concern about how those measures are collected?

7. CMS proposes to remove the following 8 measures to establish quality performance standards because they have not kept up with clinical best practice, are redundant or can be replaced with similar measures that are more appropriate for ACO quality reporting:

- ACO #12, Medication Reconciliation after Discharge from an Inpatient Facility
- ACO #22, Diabetes Composite measure: hemoglobin A1c control (<8 percent)
- ACO #24, Diabetes Composite: Blood Pressure (<140/90) (NQF #0729)
- ACO #25, Diabetes Composite: Tobacco Non-use (NQF #0729)
- ACO #23, Diabetes Composite: Low Density Lipoprotein (<100) (NQF #0729)
- ACO #29, Ischemic Vascular Disease: Complete Lipid Profile and LDL Control (<100mg/dl) (NQF #0075)
- ACO #30, Ischemic Vascular Disease: Use of Aspirin or another Antithrombotic (NQF #0068)
- ACO #32, Coronary Artery Disease (CAD) Composite: Drug Therapy for Lowering LDL Cholesterol (NQF #74)

Questions regarding the proposed removal of measures used for establishing quality performance standards for the MSSP:

a) Are there any concerns or red flags about the removal of these measures?
b) Is CMS proposing to remove the right measures from the quality measurement set?
c) Do you agree with CMS' proposal to remove these measures?
d) Do these measures no longer represent best practices?
e) Should CMS consider removing any other measures from the set? (*See Table 50, which demonstrates what measures would be used to assess ACO quality under the Shared Savings Program if CMS' proposals are finalized*)

8. CMS proposes to update the Diabetes All-or-Nothing Composite Measure.

Currently, the Diabetes All-or-Nothing Composite measure consists of the following measures:

- ACO #22: Hemoglobin A1c Control (<8 percent)
- ACO#23: Low Density Lipoprotein (<100)
- ACO#24: Blood Pressure <140/90
- ACO #25: Tobacco Non Use
- ACO #26: Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes Mellitus and Ischemic Vascular Disease

CMS proposes to update the Diabetes All-or-Nothing Composite measure to consist of the following measures:

- ACO #26: Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes Mellitus and Ischemic Vascular Disease
- ACO #27: Diabetes: Hemoglobin A1c Poor Control
- ACO #41: Diabetes: Foot Exam
- ACO #42: Diabetes: Eye Exam

CMS proposes to retire the following measures from the composite:
- ACO #22: Hemoglobin A1c Control (<8 percent)
- ACO#23: Low Density Lipoprotein (<100)
- ACO#24: Blood Pressure <140/90
- ACO #25: Tobacco Non Use

Questions regarding the proposed changes to the Diabetes All-or-Nothing Composite Measure:

a) Does CMS' proposed update to the diabetes composite measure include the right measures?
b) Is CMS retiring the right measures from the composite?
c) Are there other measures that should be removed or included?
d) Given the general concerns around composite measures and their use, CMS seeks comment on how to combine and incorporate component measure scoring for the composite. In particular, CMS is interested in whether stakeholders have any concerns about including ACO #27, reverse-scored measure, whether there are any methodological considerations we should consider when including a reverse-scored measures in composites. What are your thoughts on this?
e) Are there any other issues or changes to the diabetes composite measure that CMS should consider prior to finalizing its proposal?
f) Do the selected measures represent best practices for diabetes care?
g) Do the measures proposed for inclusion in the diabetes composite encourage the best care for diabetes patients?

9. CMS is also proposing to update the Coronary Artery Disease (CAD) Composite Measure.

Currently, the CAD Composite Measure consists of the following measures:
- ACO#32: Drug Therapy for Lowering LDL-Cholesterol
- ACO#33: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – Diabetes or Left Ventricular Systolic Dysfunction (LVEF<40%)

CMS proposes to update the CAD Composite to include the following measures:
- ACO #33: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – Diabetes or Left Ventricular Systolic Dysfunction (LVEF<40%)
- ACO #43: Antiplatelet Therapy
- ACO #44: Symptom Management
- ACO #45: Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF<40%)

CMS proposes to retire the following measure from the composite:

- ACO#32: Drug Therapy for Lowering LDL-Cholesterol

  Questions regarding the proposed update to the CAD Composite Measure:

  a) Does CMS' proposed update to the CAD composite measure include the right measures?
  b) Is CMS retiring the right measures from the composite?
  c) Are there other measures that should be removed and/or included?
  d) Does the proposed update impact - negatively or positively - the collection of the CAD composite measure?
  e) Are there any other issues or changes to the CAD composite measure that CMS should consider prior to finalizing its proposal?
  f) Do the selected measures represent best practices for CAD care?
  g) Do the measures proposed for inclusion in the CAD composite encourage the best care for patients?

10. CMS is soliciting feedback on additional measures that CMS may consider in future rulemaking.

    Questions regarding additional measures CMS is considering for the future:

    a) CMS is looking into possibly including measures that address quality of care in the various provider settings that may be part of an ACO (i.e. SNF, home health) for the MSSP. Should this be a focus area for the MSSP? If yes, do you have any recommendations or good approaches for CMS to move forward?
    b) CMS is considering whether or not to add more caregiver experience of care measures. Should this be a focus area for the MSSP? If yes, do you have any recommendations or good approaches for CMS to move forward?
    c) CMS is considering further work to align the ACO quality measures set with the measures used under the VM. Should CMS focus on this for the MSSP? If yes, do you have any recommendations or good approaches for CMS to move forward?
    d) CMS is considering whether or not to include measures that address the frail elderly population. Should CMS focus on this for the MSSP? If yes, do you have any recommendations or good approaches for CMS to move forward?
    e) Should CMS include utilization information in the aggregate quarterly reports to ACOs or should the utilization measures also be used to assess ACO quality performance as an added incentive? Please explain why.
    f) Should CMS include a self-reported health and functional status measure? Are there concerns about this type of measure due to the populations members of America's Essential Hospitals serve? Please explain why.
    g) Are there any measures CMS should consider for retirement? Measures that are either topped out or no longer represent best clinical practice. Please explain why.
    h) Should CMS include the public health measure "Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling" to the quality measure set? Are there other public health measures that CMS should consider instead? Please explain why.
    i) Are there any policies or refinements we want to use this opportunity to advance?

11. CMS proposes to revise the regulations to expressly provide that during a second or subsequent participation agreement period, the ACO would continue to be assessed on its performance on each measure that has been designated as pay for performance. That is, during subsequent agreement periods, pay for performance will apply for all three performance years. New measures that are added to the quality performance standard would be phased in along the timeline indicated when the measure is added and in operational documents.

    Current MSSP regulations can be read to imply that the quality performance standard for ACOs in the first performance year of a subsequent agreement period would also be set at the standard of full and accurate reporting. CMS noted that it does not believe it is appropriate for an ACO in a second or subsequent agreement to report quality measures and not have to meet performance goals if they have previously reported these measures in a prior agreement period.

    Question regarding CMS' clarification of the quality performance standard:

    a) Do you have any concerns about the proposed change to the quality performance standard that would apply to an ACO for subsequent participation agreement periods?

12. CMS proposes to update benchmarks every 2 years to provide ACOs with a more stable target for measuring quality improvement. Currently, CMS modifies quality performance benchmarks annually. To illustrate the change, existing quality performance benchmarks, which are based on data submitted in 2013 for the 2012 reporting period would apply for a total of 2 performance years (the 2014 and 2015 performance years) after which CMS would reset the benchmarks for all ACOs based on data for the 2014 reporting period that is reported during 2015.

    Questions regarding CMS' proposed changes on updating benchmarks:

    a) Should CMS finalize this proposal to revise the timeframe for setting benchmarks? Should CMS utilize the approach where one benchmark would apply to two performance years? Are there any concerns with this approach or revised change?
    b) Should we urge CMS to update benchmarks every 3 years to match the agreement periods?
    c) Are there any concerns or red flags about this proposed change?

13. CMS proposes to make certain modifications to the benchmarking methodology to address the way that such "topped out" measures are treated for purposes of evaluating an ACO's performance. Specifically, when the national FFS data results in the 90th percentile for a measure are greater than or equal to 95 percent, CMS would use flat percentages for the measure. CMS also seeks other approaches for addressing topped out measures.

    Questions regarding CMS' proposed modifications to addressing topped out measures:

    a) Should the criteria be consistent across federal quality reporting programs?

b) Is CMS' proposed definition for topped-out measures an accurate way to define measures that are topped-out?
c) Is your hospital doing well on measures that may be topped out soon under the proposed criteria? If yes, how would that impact your score?

14. CMS proposes to add a quality improvement measure to award bonus points for quality improvement to each of the existing four quality measure domains. For each quality measure domain, CMS would award an ACO up to two additional bonus points for quality performance improvement on the quality measures within the domain. These bonus points would be added to the total points that the ACO achieved within each of the four domains. Under this proposal, the total possible points that can be achieved in a domain, including up to 2 bonus points, could not exceed the current maximum total points achievable within the domain. For example, currently the total possible points for the patient/caregiver experience domain, which has seven individual measures, is 14 total possible points. Under this proposal to provide for quality improvement bonus points, the maximum possible points within this domain would continue to be 14. If an ACO scored 12 points and was awarded two additional bonus points for quality improvement then the ACO's total points for this domain would be 14. However, if instead this same ACO had scored 13 points, then this ACO's total points after adding the bonus points could still not exceed 14. The additional points will factor into the calculation of an ACO's shared savings.

    The quality improvement measure scoring for a domain would be based on the ACO's net improvement in quality for the other measures in the domain. Measures that were not scored in both the performance year and the immediately preceding performance year, for example, new measures, would not be included in the assessment of improvement.

    <u>Questions regarding rewarding quality improvement:</u>

    a) Has your hospital been able to improve upon your own performance?
    b) Do you think that CMS' proposal to award bonus points for quality improvement is a positive change?
    c) Are there other approaches to incentivize quality improvement that we should highlight to CMS?