III. F. Physician Compare

CMS previously finalized a decision to make public on Physician Compare the performance rates of the quality measures that group practices submit under the CY 2012 Physician Quality Reporting System (PQRS) group practice reporting option (GPRO). Therefore, CMS anticipates, no earlier than 2013, posting performance information collected through the GPRO web interface for such group practices. However, CMS previously established a minimum threshold of 25 patients for reporting measure performance on the Physician Compare website. CMS now proposes to lower this threshold to 20 patients, beginning with data collected for services furnished in 2013. This would align with the proposed minimum patient reporting thresholds for the PQRS measures group reporting for the 2013 and 2014 incentives, and the proposed reliability thresholds for the physician value-based payment modifier (discussed below in section III.K). CMS invites comment on the proposed change in patient thresholds.

CMS intends to enhance the accuracy of administrative information displayed on the Physician Compare website in CY 2012, i.e., whether a physician/other health care professional is accepting new Medicare patients, board certification information, and to improve the foreign language and hospital affiliation data. CMS also intends to include the names of those eligible professionals (EPs) who participated in the Medicare electronic health record (EHR) Incentive Program and those who satisfactorily participated under the PQRS GPRO. CMS also will continue to update the names of those eligible professionals and group practices who satisfactorily participated under the PQRS, and those who are successful electronic prescribers under the eRx Incentive Program, based on the most recent program year data available. Further, in support of the Million Hearts Initiative, CMS proposes to post the names of the eligible professionals who report the PQRS Cardiovascular Prevention measures group.

In the future, CMS proposes to make public on Physician Compare performance rates on the quality measures that group practices submit through the GPRO web interface under the 2013 PQRS GPRO and the Medicare Shared Savings Program. Also, when technically feasible, but no earlier than 2014, CMS proposes to publicly report composite measures that reflect group performance across several related measures. Toward this end, Table 35 of the proposed rule proposes to add composite measures for diabetes and coronary artery disease into the PQRS starting in 2013, and CMS says it will consider future development of other composite measures in the future.

CMS also proposes to add patient experience survey-based measures, i.e., the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) for group practices participating in the PQRS GPRO and for Accountable Care Organizations (ACOs). Both for group practices and ACOs, the CAHPS measures for 2013 would include the following: Getting Timely Care, Appointments, and Information; How Well Your Doctors Communicate; Patients’ Rating of Doctor; Access to Specialists; and Health Promotion and Education. For ACOs, there is one additional CAHPS measure, Shared Decision Making. **CMS invites comment on its proposal to begin publicly reporting patient experience data for program year 2013, and also the alternative option of delaying public**
reporting until program year 2014 in order to give group practices and ACOs the opportunity to make changes to the processes used in their practices based on the review of their data from program year 2013.

CMS further proposes posting the names of those physicians who earned a PQRS Maintenance of Certification Program incentive no sooner than 2014. CMS is also considering allowing measures that have been developed and collected by “approved and vetted specialty societies” (Boards approved as MOC Incentive entities?) to be reported on Physician Compare, “as deemed appropriate, and as they are found to be scientifically sound and statistically valid.” CMS also proposes to include additional claims-based process, outcome and resource use measures on Physician Compare. As an initial step, CMS proposes to include group level ambulatory care sensitive condition admission measures of potentially preventable hospitalizations, no earlier than 2015, for those group practices comprised of 2-99 eligible professionals participating in the 2014 PQRS GPRO and for ACOs. The next proposed step would involve publicly reporting performance rates on quality measures included in the 2015 PQRS and value-based payment modifier for individual eligible professionals.

For all measures publicly reported on Physician Compare, CMS proposes to post a standard of care, such as those endorsed by the National Quality Forum. CMS says that such information will serve as a standard for consumers to measure individual provider and group level data. CMS adds that it will only post data on Physician Compare “if it is technically feasible; the data is available; the system is set up/adjusted to post information and the data is useful, sufficiently reliable, and accurate.”

CMS seeks comments on their proposals to:

1. Reduce the minimum reporting threshold from 25 to 20 patients for reporting measure performance rates on Physician Compare
2. Post names of EPs who report the PQRS Cardiovascular Prevention measures group for recognition in the Million Hearts campaign
3. Develop composite measures at the disease module level, initially with 2013 GPRO data
4. Publicly report 2013 patient experience data for group practices participating in 2013 PQRS GPRO or who are part of an ACO in the Shared Savings program
5. Alternative option of providing confidential feedback to group practices and ACOs on 2013 patient experience data to allow changes to processes prior to publicly reporting 2014 data
6. Report names of participants who earn a 2013 PQRS MOC Program incentive no earlier than 2014
7. Allow measures that have been developed and collected by specialty societies (Boards?) to be reported on Physician Compare as appropriate
8. Report 2014 group level ambulatory care sensitive condition measures of potentially preventable hospitalizations (AHRQ measures) no earlier than 2015 for groups in the 2014 PQRS and ACOs
9. Publicly report performance data on 2015 PQRS and the value-based payment modifier quality measures for individuals (no earlier than 2016)
10. Post a standard of care for measures posted on Physician Compare

III. G. Physician Quality Reporting System (PQRS)

1. Methods of Participation (Individual or Group Practice) pg 294

Definition of Group Practice (for purposes of GPRO): CMS proposes that a group practice be defined as a single TIN with 2 or more eligible professionals, as identified by their individual NPI, who have reassigned billing rights to the TIN (as opposed to 25 or more as in 2012).
**Administrative claims-based reporting option (pg 318, discussed more fully in Section K, pg 581)**

CMS proposes to provide an option for eligible professionals (EP) and group practices to select an administrative claims-based reporting method for purposes of the PQRS payment adjustment for 2015 and 2016 only. Under this option EPs would not be required to submit quality data codes on claims as in the traditional claims-based reporting. Instead, CMS would analyze every claim from an individual or group practice that elected to use the option, to determine if any of the clinical quality actions of the proposed measures were performed. This is similar to how the administrative claims-based Imaging Efficiency measures in the Hospital Outpatient Quality Reporting program are calculated. The proposed measures are not measures that would typically be applicable to diagnostic radiologists, i.e. Short Term Diabetes Complications, Admission for COPD, Osteoporosis Management. Many of these measures are hospital based, e.g. All Cause Readmissions, but the physician or group practice is being measured based on assigned beneficiaries’ outcomes, basically.

CMS is proposing that this method be an alternative method of satisfactory reporting for determination of the payment adjustment in 2015 and 2016. That is, if a physician or group practice elects to use the administrative claims-based option, they meet the criteria for satisfactory reporting. This is discussed more in the section below “**Criteria for satisfactory reporting for 2015 and 2016 payment adjustment**”.

**III G. 1. (4) Reporting periods for Payment Adjustment in 2016 and beyond Pg 299**

Propose an additional reporting period of 6 months (July-Dec 2013) for reporting measures groups via registry, and July – Dec 2014 for 2016 adjustment. Beginning 2017, only 12months reporting period will be an option.

**Criteria for satisfactory reporting for the 2013 and 2014 incentives for individual EPs Pg 328**

*Individual measures:*

No changes to criteria for satisfactorily reporting individual measures via claims or registry.

For EHR reporting in 2013:

- Option 1: Report on ALL three PQRS EHR measures that are also Medicare EHR Incentive Program core measures. If the denominator for one or more of the Medicare EHR Incentive Program core measures is 0, report on up to three PQRS EHR measures that are also Medicare EHR Incentive Program alternate core measures;
  AND report on three additional PQRS EHR measures that are also measures available for the Medicare EHR Incentive Program.

  Option 2: Report at least 3 measures, AND report each measure for at least 80 percent of the eligible professional’s Medicare Part B FFS patients seen during the reporting period to which the measure applies.

For 2014 2 options:

- Option 1a: Select and submit 12 clinical quality measures available for EHR-based reporting from Tables 32 and 33, including at least 1 measure from each of the identified 6 domains – (1) patient and family engagement, (2) patient safety, (3) care coordination, (4) population and public health, (5) efficient use of healthcare resources, and (6) clinical process/effectiveness.
Option 1b: Submit 12 clinical quality measures composed of all 11 of the proposed Medicare EHR Incentive Program core clinical quality measures specified in Tables 32 and 33 plus 1 menu clinical quality measure from Tables 32 and 33.

Measures groups:
For claims reporting, reduce sample size to at least 20 patients (vs 30); removing option to report on at least 50% of patients applicable to measures group (but minimum of 15).

For registry reporting for 2013/2014 either a 12 or 6 month reporting period, report on at least 20 patients. These may be non-Medicare (when reporting through registry, patient data may be stripped so difficult to distinguish if Medicare or not).

Group Practice Reporting Option (GPRO) Pg 331
In 2012, CMS opened up GPRO reporting to smaller group practices of 25 to 99 EPs, as well as the existing GPRO for groups of 100+. Reporting is done on a select set of primary care measures. Groups report quality data through a CMS web portal which has been pre-populated with a sample of patients who have been assigned to the group based on primary care services furnished by the practice. Group practices self-nominate and CMS selects groups to participate.

For 2013, CMS proposes to open up GPRO participation to groups as small as 2, and allow participation through claims, registry or EHR instead of only through the web-interface (which is populated with a sample of assigned beneficiaries based on primary care visits). Additionally, CMS proposes to allow groups to report on any 3 measures – not just the short list of largely primary care measures. It seems this could allow even diagnostic radiology groups to use GPRO reporting, however clarification is needed that the beneficiary assignment methodology previously used is not a requirement for a GPRO of 2-99 EPs using claims, registry or EHR reporting. If GPRO is an option for radiology, individuals who cannot report any measures but whose group can report 3, will be able to show successful participation. Additionally, it will open up the option for more practices to use registry reporting (since 3 measures are required for that mechanism).

Group practices must self-nominate and be selected by CMS to participate in GPRO. The group will need to indicate which reporting mechanism (claims, registry, EHR, web interface) the practice intends to use for the specific reporting period. This would be the only method by which the practice can use. Also, individual EPs that are part of a group practice participating in GPRO cannot report as individual EPs.

The size of the group practice must be established at the time the practice is selected to participate in GPRO since there are different criteria for satisfactory reporting based on group size. Groups that been selected for GPRO and that change TINs during the reporting year will no longer be eligible to participate in GPRO for that year, however the EPs in the practice may still participate as individuals.

Criteria for satisfactory reporting for group practices selected to participate in GPRO Pg 330

GPRO Web Interface
CMS proposes that group practices of 25-99 or 100+ use the GPRO web interface for reporting in 2013 and 2014. That approach requires beneficiary assignment based on primary care visits. Radiologists that are part of a multi-specialty practice could participate in this way. Some interventional practices and radiation oncology practices may also be able to participate through the web interface method. The measures that must be reported in this option are mostly primary care focused. The requirements for
satisfactory reporting for GPRO web interface are thus somewhat different than the newly proposed GPRO mechanisms of claims, registry and EHR reporting:

Report data in the web interface on the first 218 or 411 (based on group size) consecutively ranked/assigned beneficiaries in the group’s sample for each measure module. If there are less than 218/411 patients, report on 100 percent of patients.

Groups of 100+ are required to use the web interface tool.

**GPRO claims, registry and EHR reporting**

CMS is not proposing use of the GPRO web interface for groups of 2-24 because smaller practices tend to be more focused on a limited set of specialties and would not be able to report on a measure set that covers multiple domains of care as is required using the web interface. However, in 2012 group practices of 2-24 in GPRO must use the web interface. For 2013 and 2014, CMS does propose that groups 25-99 could use the web interface, but also proposed they could use claims, registry and EHR reporting. CMS states there is limited data on whether the GPRO web interface is viable for smaller practices, since 2012 is the first year it has been available to smaller groups.

For the 2013 and 2014 incentives the criteria for satisfactory reporting of individual measures by GPRO-selected practices using claims, registry or EHR mechanisms are similar to the criteria for individual EPs. CMS believes smaller group practices are more similar to individual EPs in terms of practice scope. The criteria are:

**Claims (2-99 EPs):** Report at least 3 measures and report each measure for at least 50% of the group practice’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Zero percent performance rate is not counted.

**Registry (2-99 EPs):** Report at least 3 measures and report each measure for at least 80% of the group practice’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Zero percent performance rate is not counted.

**EHR (2-99 EPs):**

**2013:** Option 1: Report on three Medicare EHR Incentive Program core measures or alternate core measures. Further requirements are in the EHR program Stage 1 final rule. Zero percent performance rate is not counted.

Option 2: Report at least 3 measures, AND report each measure for at least 80% of the group practice’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Zero percent performance rate is not counted.

**2014:**

Option 1a: Select and submit 12 clinical quality measures available for EHR-based reporting from Tables 32 and 33, including at least 1 measure from each of the identified 6 domains – (1) patient and family engagement, (2) patient safety, (3) care coordination, (4) population and public health, (5) efficient use of healthcare resources, and (6) clinical process/effectiveness.
Option 1b: Submit 12 clinical quality measures composed of all 11 of the proposed Medicare EHR Incentive Program core clinical quality measures specified in Tables 32 and 33 plus 1 menu clinical quality measure from Tables 32 and 33.

Option 2: Report at least 3 measures and report each measure for at least 80 % of the group practice’s Medicare Part B FFS patients seen during the reporting period to which the measure applies.

Zero percent performance rate is not counted.

Analysis of criteria for satisfactory reporting for the 2013 and 2014 incentives pg. 343
CMS proposes that individual EPs and group practices may not combine methods of participation for meeting requirements for satisfactory reporting for the 2013 and 2014 incentives. For example, a physician would not be able to report on 2 measures through claims and 1 through a registry. However, an individual or group could use two methods, satisfactorily report through either and obtain one incentive payment. CMS would use whichever reporting method yields the greatest bonus.

Criteria for satisfactory reporting for 2015 and 2016 payment adjustment Pg 344
CMS proposes that if a physician or group practice meets the requirements for satisfactory reporting for the 2013 and 2014 incentive, then they will also meet the requirement for avoiding the payment adjustment. For EPs also participating in the EHR Incentive program, the criteria for successful reporting for 2015/2016 payment adjustment determination will be the same criteria for meeting the CQM component of meaningful use applicable during the 2015/2016 payment adjustment reporting periods (2013/2014). This allows the physician to submit only a single set of data for EHR incentive and PQRS.

CMS is also proposing alternative criteria for satisfactory reporting for the 2015/2016 payment adjustment determination based on their stated goals of encouraging participation and to alleviate new participants’ need to become familiar with the program. For these two years, EPs or group practices can report 1 measure or 1 measures group when using claims, registry or EHR-mechanisms to meet requirements. It is unclear if CMS intends not to have a reporting level (sample size) requirement (either 50% for claims or 80% for registry/EHR). In 2017 and beyond, CMS anticipates eliminating this option and reverting to the more stringent criteria that is currently required for the incentive in 2013 and 2014.

Alternatively, CMS is proposing that individuals or group practices who report but fail to meet the 2013 and/or 2014 incentive reporting criteria to be defaulted to use of the administrative claims-based reporting option. Thus, CMS would analyze the claims of a physician/group who reported 1 measure in 2013 and 2014 to determine if any of the clinical quality actions of the proposed measures were performed. CMS does not indicate whether a physician would be considered satisfactorily reporting if none of the clinical actions were performed or if the measures do not apply to the EPs’ patients.

The administrative claims-based option will also be discussed below in regards to its use for the Value Modifier.

Analysis of individuals and group practices that will be assessed a PQRS payment adjustment Pg 349
Individual EPs are assessed at the TIN/NPI level; group practices selected to participate in GPRO are assessed at the TIN level. Changes in a TIN/NPI or a group’s TIN may occur between the end of a reporting period and the time of payment adjustment application, which raises issues about the
subsequent application and the potential for abuse, or gaming. CMS would like comments on what parameters, if any, CMS should impose regarding changes to TIN/NPIs with regard to the adjustment.

**Criteria for reporting for the payment adjustments for 2017 and beyond pg 350**

CMS states it is important to have a time period that allows those that are new to PQRS to gain experience in reporting requirements. It is their intention though that as the reporting period approaches that will serve solely for payment adjustments (2015, when the incentives end) to expect that the requirements for satisfactory reporting used to determine the payment adjustment should be the same as expected to achieve the incentive. **CMS invites comments for future criteria for satisfactory reporting requirements for the 2017 payment adjustment period that are identical to the 2014 incentive payment requirements; comments on alternative criteria are invited.**

Treble period 2013: period for incentive, basis for payment adjustment, basis for value modifier

**Selection of PQRS quality measures for 2013 and beyond pg 351**

CMS reiterates its position that statutorily measures selected for the program must be endorsed by [NQF]. However, if there is a specified area or medical topic determined appropriate for which there is not an endorsed measure, CMS may use one that is not. Additionally, the PPACA requires CMS to receive pre-rulemaking input from a multi-stakeholder group that would provide a transparent process for selecting quality measures to be used in PQRS (and other reporting programs). The NQF-convened Measures Application Partnership provided such input with the exception of the administrative claims-based measures to be used to align with the Value Based Modifier and the measures used to align with the Shared Savings Program.

In order to align with proposed measures for the EHR Incentive Program, CMS has classified proposed PQRS quality measures (existing and new) against the six domains in the National Quality Strategy:

1. Patient and Family Engagement
2. Patient Safety
3. Care Coordination
4. Population and Public Health
5. Efficient Use of Healthcare Resources
6. Clinical Processes/Effectiveness

**Proposed Measures: pg 328**

**Individual Measures:**

1. Individual Core Measures (claims, registry, EHR) for 2013 and beyond – 7 measures which support the Million Hearts Initiative, Diabetes care and Preventive Care and Screening. CMS is proposing not to require EPs to report on these core measures (as was required in 2012).
2. PQRS Individual Quality Measures (claims, registry, EHR) (potentially pertinent to radiologists)
   a. Included in 2012 but not 2013 (to be dropped) and beyond:
      - #10 Stroke/Stroke Rehab CT/MRI Reports; NQF endorsement lapsed due to testing data, currently under review, NQF Neurology Steering Committee did not recommend endorsement, MAP did not recommend
   b. Included in 2012 and proposed for 2013 and beyond:
      - #20-23 Perioperative care set (interventional)
      - #24, #40 Osteoporosis (interventional)
      - #71 Breast cancer hormonal therapy (some RO's)
      - #76 CVC Insertion protocol (interventional)
• #102, #104, #105 Prostate cancer (RO); #105 is proposed to be dropped in 2014 – it is being retired by the measure owner
• #143, #144 Oncology (RO)
• #145 Fluoro dose/time recorded
• #146 Inappropriate use of probably benign code (BIRADS 3)
• #147 NM Correlation of bone studies
• #156, #194 Oncology (RO)
• #195 Stenosis measurement in carotid imaging reporting
• #225 Reminder system for mammograms
• #265 Biopsy follow up

c. New for 2013 and beyond (not available in 2012):
• Cardiac stress imaging not meeting appropriate use criteria-preop evaluation in low risk surgery patients (registry only) (ACC measure)
• Cardiac stress imaging not meeting appropriate use criteria – routine testing after PCI (registry only) (ACC measure)
• Cardiac stress imaging not meeting appropriate use criteria – testing in asymptomatic, low-risk patients (registry only) (ACC measure)

d. New for 2014 and beyond:
• Radiation Dose Optimization: Utilization of standardized nomenclature for CT imaging description
• Radiation Dose Optimization: Count of potential high dose radiation imaging studies (CT and Cardiac Nuclear Med)
• Radiation Dose Optimization: Reporting to a radiation dose index registry
• Radiation Dose Optimization: Images available for patient follow up and comparison
• Radiation Dose Optimization: Search for prior imaging studies through a secure, authorized, media-free shared archive

The Radiation Dose Optimization measures were developed through the PCPI with ABMS, ABR and ACR as lead societies. They are currently being specified by AMA staff and will go to PCPI vote in the next month or so. Following that they will need to be tested and submitted to NQF.

In 2012, CMS aligned any EHR-specified measures between PQRS and the EHR Incentive program. CMS proposes to retain all those measures for 2013 and beyond and will continue to align measures in the programs. CMS also intends to align the PQRS measure set with the Value-based Modifier and Shared Savings programs.

In summary, for 2013 CMS is proposing a total of 264 individual measures, 250 of which were previously used for 2012 PQRS. 14 are newly proposed in 2013; 14 others are proposed for retirement (including the CT/MRI Reports measure #11). In 2014, CMS proposes adding 34 additional new measures (including several from the ABMS/ABR/ACR/PCPI Radiation Dose Optimization measure set (now titled Optimizing Patient Exposure to Ionizing Radiation), and proposes to retire 8 measures (including #105, 3D Radiotherapy for Prostate Cancer).

Measures Groups
For 2013:
CMS proposes 21 measures groups for 2013 PQRS reporting, including the Perioperative Care measures group potentially reportable by interventional radiologists, as well as a new one “Oncology” (breast and cancer care) that radiation oncologists may be able to report.

For 2014:
CMS proposes 4 additional measures groups in 2014, including “Radiation Dose” which is comprised of the Radiation Dose individual measures mentioned above.

**Maintenance of Certification pg 524**
The self-nomination requirements for “entities” or Boards that want to submit MOC information for their members that CMS proposes is identical to 2011 and 2012. CMS states that the incentives only run through 2014.

**Informal review pg 527**
CMS established an informal review process for 2012. CMS proposes additional parameters for EPs and group practices subject to a PQRS payment adjustment requesting a review, e.g. a request for review must be submitted by February 28 of the year in which the payment adjustment will be applied. So, if an EP does not satisfactorily meet PQRS requirements in 2013 and is subject to a 1.5% payment adjustment in 2015, they must request a review by February 28, 2015.

CMS states that this deadline should provide “ample time for EPs/groups to discover that their claims are being adjusted”. CMS proposes that if the EP or group was subsequently considered to have satisfactorily report, then application of the adjustment would cease and claims would be reprocessed.

**III. H. EPrescribing pg 528**

**PQRS EHR Incentive pilot pg 545**
The PQRS EHR Incentive pilot was established in CY 2012 to pilot electronic submission of clinical quality measures (CQMs) for the EHR Incentive program (MU) and to move towards alignment of quality reporting requirements for Stage 1 MU and PQRS. An EP participating in the pilot is able to report CQM data extracted from Certified EHR technology via use of a PQRS qualified EHR product or EHR data submission vendor product. CMS proposes to extend the pilot for 2013 payment year identical to how it was finalized for 2012. In addition, CMS is proposing for 2013 payment year, to extend the use of attestation as a reporting method for the CQM component of MU for the EHR Incentive program. In 2013, EPs would be able to report attestation on CQMs as calculated by certified EHR.

**III. I. Shared Savings program pg 547**
In the Shared Savings Program Final Rule, CMS finalized the PQRS reporting requirements for incentive payments. EPs who are ACO providers/suppliers are considered a group practice for purposes of qualifying for a PQRS incentive under the Shared Savings Program (SSP). The ACO, on behalf of its ACO provider/suppliers must satisfactorily report the measures required under the SSP, that is, the 22 GPRO quality measures that are submitted through the GPRO web interface (these are the primary care measures for assigned beneficiaries as described on page 3 above). ACOs must submit PQRS data through the GPRO web interface.

For years when a PQRS incentive is available (2013/2014), an EP that participates in an ACO as provider/supplier and the ACO qualifies for the incentive; the payment (0.5%) will be made to the ACO TIN based on allowed charges of the ACO providers/suppliers. ACO participant TINs or ACO
provider/suppliers who are EPs cannot earn a PQRS incentive outside of the SSP, or through the traditional PQRS program.

In regards to the PQRS payment adjustment, CMS proposes for the adjustment requirements to be consistent with the requirements for ACO PQRS incentive payments, as described above. So, if an ACO satisfactorily reports the ACO GPRO web interface measures during the applicable reporting period, its participant TINs with ACO providers/suppliers who are EPs will not be subject to the PQRS payment adjustment.

Regarding EPs moving across programs and reporting options from year to year – as long as an EP satisfactorily reported for purposes of the payment adjustment during the applicable reporting period, CMS proposes that the EP should not be subject to the payment adjustment even if reporting under a different method than at the time the adjustment would be assessed.

III. K. Physician value-based payment modifier and the Physician Feedback Reporting program pg 559

Background: The PPACA requires the establishment of a payment modifier that provides for differential payment to a physician or group of physicians under the PFS based upon the quality of care compared to cost during a specific performance period. It also requires application of the payment modifier beginning January 1, 2015 to specific physicians and groups of physicians determined appropriate. It allows for the modifier to begin no later than January 1, 2017.

The Act requires that CMS should provide Physician Feedback reports to physicians or physician groups that measure the resources involved in furnishing care to Medicare beneficiaries and authorizes inclusion of information on the quality of care furnished by these physicians.

Overview of Proposals: In developing proposals for implementing the value-based modifier, CMS reviewed experience of the Physician Feedback report over the past 3 years during which different methodologies were tested and stakeholder feedback was obtained. CMS also linked PQRS with the Physician Feedback reports by including PQRS measures reported by physicians and groups in the latest version of the Feedback reports. CMS proposes to begin implementing the value based modifier by focusing on prevention and effective chronic disease care and by encouraging high quality care for the most difficult cases. CMS recognizes that physician quality measurement is still evolving and methodologies are still developing.

CMS designed their proposals to 1) provide groups of physicians with 25 or more EPs an option that their value based modifier be calculated using a quality tiering approach 2) focus payment adjustment (upward and downward) on groups of physicians that are outliers and 3) align the value based payment modifier with PQRS and Medicare claims data to reduce administrative burden on EPs. CMS believes that their proposals are scalable to smaller groups of physicians/solo practitioners who will be subject to the value-based payment modifier beginning in 2017. CMS seeks comment on the potential for proposals to be applied to all physicians.

CMS’ proposed scoring methodology for the value based payment modifier would assess quality of care furnished compared to cost to calculate a payment adjustment. Intending to align QI programs, the scoring methodology relies partially on PQRS data submission. In beginning the implementation, CMS proposes to separate all groups of physicians with 25 or more EPs into two categories based on choice of PQRS participation:
1. Groups that have satisfactorily reported PQRS quality measures data for 2013/2014 incentives or satisfactorily reported using the administrative claims-based mechanism. For the 2015/2016 payment adjustment CMS proposes to set the initial value based payment modifier at 0.0% for these groups of physicians, thus payments would not be affected.

These groups would have the option for the value based modifier to be calculated using a quality-tiering approach with the opportunity to earn an upward payment adjustment for high performance (high quality/low cost) and to be at risk for downward adjustment for poor performance (low quality/high cost). The exact amount of the upward payment adjustment cannot yet be determined because of the budget-neutrality requirement and a proposed downward limit of -1.0% initially.

2. Groups that have not met the PQRS satisfactory reporting criteria, including groups that have decided not to participate in any PQRS reporting mechanism. Without the PQRS quality data to assess quality of care, CMS proposes to set the 2015 value based payment modifier for these groups to -1.0 (more detail below). This negative adjustment would be in addition to the -1.5% payment adjustment for failing to meet the satisfactory reporting criteria under PQRS.

Overview of Payment Modifier pg 563
CMS outlines its goals for physician value-based purchasing similar to other value-based purchasing initiatives: recognize/reward high quality care and quality improvements and promote efficiency and effectiveness through evidenced based measures, less rework/duplication/fragmentation. CMS seeks to move quickly to the use of outcome and patient experience measures. Because of the centrality of physicians for these goals, CMS believes that in the long run the value based payment modifier should rely on measuring physician performance (both quality and cost) at four levels - the individual physician, group practice, facility and community.

Based on experiences from several demonstration projects, PQRS results and the Physician Feedback reports, CMS believes the value based payment modifier and the Physician Feedback reports can be used to incentivize and reward high quality, efficient care by providing upward/downward to physicians based on performance. CMS outlines several principles for implementing the modifier:

1. Focus on measurement and alignment. CMS proposes that measures should be consistent with the National Quality Strategy and across CMS quality initiatives (PQRS, Shared Savings, EHR Incentive) and seeks to expand quality measures for the value based payment modifier. CMS encourages physicians to work with them to include additional meaningful quality measures.

2. Focus on physician choice. CMS states physicians should be able to choose the level of assessment across practice configurations and should be aligned with requirements of other quality reporting programs (PQRS, EHR Incentive). CMS proposes to rely on quality measure data from the PQRS GPRO and EHR Incentive program for most performance data for the value based payment modifier.

3. Focus on shared accountability. CMS believes the value based payment modifier can facilitate shared accountability by assessing performance at the practice group level and focusing on total costs of care not just costs furnished by an individual physician. CMS seeks
to begin evaluating how to incorporate individual, hospital-based and community-based quality and cost measures as a component of the value based payment modifier.

4. Focus on actionable information. CMS should provide meaningful information to encourage performance improvement and states the Physician Feedback reports can serve that purpose.

5. Focus on gradual implementation. CMS believes the value based payment modifier should initially focus on outliers and that physicians should elect how the modifier would apply in 2015. CMS states as they gain experience with measurement tools the scope of measures can be broadened, refining focus and payment distinctions.

Proposals for the Value-based Payment Modifier pg 571

a. Proposed application pg 571

(1) General: The value based modifier (value-based payment modifier) is to be applied to all physicians and groups of physicians (as defined in section 1861 (r)). CMS proposes to initially include groups of physicians of 25 or more EPs under a single TIN as identified by their individual NPIs who have reassigned their Medicare billing rights to the TIN. The value-based payment modifier will only be applied to services billed by physicians under the TIN, not to other EPs that may bill under the TIN, i.e. physical therapists, physician assistants, etc.

(2) Application at group level: The application of the value-based payment modifier at the TIN level means that CMS would not track/carry a physician’s performance from one TIN to another (TIN value-based payment modifier at the time will apply). CMS believes payment at the group level reflects the view that the group in which a physician practices matters and that it will be more straightforward to apply the same value-based payment modifier to each physician in the group. CMS seeks comments on these proposals.

CMS believes it is reasonable to phase in the value-based payment modifier using group performance since physicians have been submitting quality data at the group level since 2011. Also the PPACA requires CMS to implement the value-based payment modifier in a “manner that promotes systems-based care” and CMS believes this can be done through processes and workflows that 1) make effective use of information technologies 2) develop effective teams 3) coordinate care across patient conditions, services and over time and 4) incorporate measurement for improvement and accountability. CMS believes groups have the ability and resources to redesign these to meet the stated goals.

(3) Smaller groups/solo practitioners: Starting in 2017, CMS would apply the value-based payment modifier to all physicians and groups of physicians. CMS seeks comment as to whether individual physicians and groups with less than 25 EPs should be offered an option that their value-based payment modifier be calculated using a quality-tiering approach starting in 2015 (vs having the payment adjustment applied or not based on satisfactory reporting). CMS could calculate the value-based payment modifier for groups of 2 EPs and apply the value-based payment modifier at the TIN level the same as for groups of 25 or more. CMS also seeks comments as to how to do this for solo practitioners.

(4) Hospital based physicians: CMS also seeks comments on whether they should develop a value-based payment modifier option for hospital-based physicians to elect to be assessed based on the performance of their hospital, using measure rates the hospitals report under the Inpatient Quality Reporting (IQR) or Outpatient Quality Reporting (OQR) programs. If so, CMS seeks comments on which
IQR/OQR measures (and applicable reporting period) would be appropriate to include. **CMS also seeks comments on a way to determine whether physicians are hospital based.**

(5) **System for choosing value-based payment modifier calculation option:** CMS seeks comments on how groups of 25 or more should request to have the value-based payment modifier calculated using the quality-tiering approach. CMS proposes building on the GPRO self-nomination process, which may be done through submitting statements through web-based functionality or through letter. CMS proposes establishing a web-based registration system that permits groups to request the value-based payment modifier quality tiering, throughout 2013 rather than submit a statement by January 31, 2013 as proposed in the PQRS self-nomination process. Another approach would be to require groups submit a letter to CMS in a “timely manner”. **Comments requested.**

(6) **Tiering for Shared Savings Groups or Pioneer ACOs:** CMS proposes not to offer the quality-tiering approach for groups of 25 or more that are participating in the Shared Savings or Pioneer ACO Programs, assuming they had satisfactorily reported PQRS. Shared Savings ACOs will be pay-for-reporting in 2013; Pioneer ACOs will be pay-for-performing in 2013. **CMS seeks comments on ways to structure the value-based payment modifier starting in 2017 so not to create conflict with the goals of these two programs. Or should CMS permit these groups to use the value-based payment modifier quality-tiering starting in 2015.**

(7) **Eligibility:** The value-based payment modifier does not apply to services physicians furnish in Rural Health Clinics, Federally Qualified Health Centers or Critical Access Hospital billing under method II (not considered billing under PFS).

b. **Proposed performance period pg 578**

CMS finalized in the CY 2012 PFS Final Rule that 2013 would be the initial performance period for the value-based payment modifier that will be applied to payments in 2015. Similarly, CMS proposes that 2014 would be the performance period for application of the value-based payment modifier in 2016. **CMS continues to seek ways to provide more timely feedback and narrow the gap between performance periods and payment adjustment periods and seek comments on alternatives to do so.**

c. **Proposed quality measures pg 579**

(1)**Alignment of value-based payment modifier reporting with PQRS reporting:** CMS proposes that for groups of physicians that have met the PQRS satisfactory reporting criteria and that request their value-based payment modifier be calculated using the quality-tiering approach, that the performance rates on the quality measures reported through any of the PQRS GPRO mechanisms (web-interface, claims, registries, EHRs or administrative claims-based option) be used to determine the tiering. CMS seeks comments on this proposal. CMS is concerned that some groups (who request quality-tiering) may attempt to report using one of these methods, yet may fail to do so, be categorized as a non-PQRS reporter and then be subject to the -1.0 downward adjustment. To address this issue, **CMS proposes and seeks comments as to whether to assess performance on the measures included in the administrative claims-based reporting option as a default if a group does not meet PQRS criteria for satisfactory reporting.** (Need clarification if the administrative claims-based reporting is actually an option for radiologists).

**Individual physicians: CMS seeks comments on which PQRS reporting mechanisms should be offered to individual physicians if the value-based payment modifier were applied to their PFS payments**
**beginning in 2015 and 2016.** Individual physicians can report individual measures or measures groups through claims, registry or EHRs.

(2) **Quality measure alignment with PQRS**

**CMS seeks comments on their proposal to include all individual measures identified for reporting through PQRS GPRO web interface, claims, registries or EHRs for 2013 and beyond for the value-based payment modifier** (Tables 30 and 32). Need to clarify not measures groups and why?

**CMS also seeks comments on what quality measures should be proposed for individual physicians if they are provided the ability to elect to have the value-based payment modifier applied to payments in 2015 and 2016.**

(3) **Administrative claims option under PQRS**

CMS proposes to provide the administrative claims-based reporting option for purposes of the payment adjustment in 2015 and 2016 only. CMS sees two issues with this reporting option as it relates to the value-based payment modifier: 1) level to assess the measures (individual or group) and 2) scope of quality measures that will be assessed using administrative claims.

*Level of performance:* CMS feels measurement and assessment at the individual level (NPI) provides actionable information for improvement by physicians and can incentivize accountability for quality and cost, however there are issues with insufficient case numbers that could result in statistically unreliable performance rates affecting payment. Assessment at the group level (by TIN) allows for larger case count/more reliability, as well as enabling CMS to calculate a broader range of measure topics. For these reasons, CMS proposes for the value-based payment modifier to assess performance rates in the administrative claims-based option at the group (TIN) level and apply the calculated score and resulting value-based payment modifier to all physicians that bill under that TIN during the payment adjustment period.

*Scope of measures:* CMS proposes to include in the administrative claims-based reporting option for 2015 and 2016 15 of the 28 quality measures that were included in the Physician Feedback reports distributed to 23,000 physicians in Iowa, Kansas, Missouri and Nebraska in March 2012. CMS believes these are clinically meaningful, focus on highly prevalent conditions, have the potential to differentiate physicians, and are reliable. These measures are similar to those adopted in private sector programs. **CMS seeks comments on whether to include all 28 measures (41 with sub-measures) from the March 2012 reports.**

(4) **Outcome measures for groups of physicians**

In CY 2012 PFS, CMS finalized for physicians practicing in groups (participating in GPRO?) that the rates of potentially preventable hospital admissions for two ambulatory sensitive conditions (heart failure and COPD) would be calculated. CMS proposes to include four outcome measures in the value-based payment modifier for all groups of physicians with 25 or more EPs, regardless of which reporting mechanism the group uses.

The current Physician Feedback reports include six outcome measures for potentially preventable hospital admissions, three on chronic conditions (heart disease, COPD and diabetes) and three on acute conditions (dehydration, UTI, bacterial pneumonia). CMS proposes to create two composite outcome measures (chronic/acute) for the value-based payment modifier, since many groups of physicians may have relatively few of these admissions for a given condition.
CMS also proposes to use two care coordination measures at the group level – all cause hospital readmissions (currently used in the Shared Savings Program) and 30-day post-discharge visit measure in the PGP Transition Demo.

**CMS seeks comment on the inclusion of these four outcome measures (two composites, two care coordination).**

CMS is not making any proposals at this time to assess community level performance but seeks comments as to the benefit of doing so.

**d. Proposed cost measures pg 588**

In CY2012 Final Rule, CMS finalized total per capita cost measures and per capita cost measures for four chronic conditions (COPD, heart failure, CAD and diabetes) for use in the value-based payment modifier. Total per capita costs include Part A and Part B, but not Part D. CMS proposes use of 60 day run out (i.e. claims paid through March 1 for year-end December 31) and seeks comment on that.

These measures were used in the 2010 Physician Feedback reports and will be included in the 2011 reports expected out later in 2012. CMS proposes to continue to use these five measures to calculate the cost composite for the value-based payment modifier.

**(1) Proposed payment standardization methodology for cost measures pg 589**

The ACA requires CMs to standardize Medicare payments to ensure fair comparisons across geographic regions when using cost measures. CMS is proposing to use the payment standardization methodology that is currently used in the hospital feedback reports for the Medicare Spending per Beneficiary measure, rather than the methodology used in the 2010 Physician Feedback reports that standardized at the regional level and used averaging. In the 2011 Physician Feedback reports for distribution in 2012, CMS will use the national payment standardization methodology (as outlined below) and will use this methodology for the value-based payment modifier.

- Eliminates adjustments for national payment amounts that reflect PE and regional labor cost differences (through GPCI and hospital wage index)
- Substitutes a national amount vs a state fee schedule
- Eliminates supplemental payments to disproportionate share hospitals, or for indirect graduate medical education
- Removes incremental payments for community hospitals and Medicare-dependent hospitals above their base payments
- Eliminates certain rural add-on payments (inpatient psychiatric and rehabilitation)
- Eliminates PFS incentive payments for physicians in rural, underserved communities

**CMS seeks comments on this proposed standardization methodology.**

**(2)Risk adjustment methodology for costs measures pg 592**

CMS is also required by statute to use risk adjustment for cost measures. CMS proposes to use for the value-based payment modifier the same risk adjustment model for the total per capita costs and the total per capita costs per beneficiary for four chronic diseases measures as were used in the 2010 Physician Feedback reports. This model adjusts for patient demographics (age, gender, socioeconomic-
dual eligible status, prior health conditions), using the CMS Hierarchical Condition Categories (HCC) model. The HCC incorporates beneficiary characteristics and prior year diagnoses to predict relative Part A and Part B payments and assigns prior year ICD9CM diagnosis codes to 70 generally high-cost clinical conditions to capture medical risk. ESRD status is also included.

**CMS seeks comments on the proposed risk adjustment methodology.**

**e) Attribution of quality and cost measures pg 595**

CMS states they must attribute beneficiaries to groups of physicians in order to calculate performance rates of administrative claims-based quality such as the PQRS measures of that type or the GPRO measures submitted through the web interface. They must also attribute beneficiaries to groups of physicians reporting quality data through GPRO in order to calculate cost measure performance rates. In the 2010 Physician Feedback reports CMS used two methods: 1) for individuals, “degree of involvement” (explained below) and 2) for groups, “plurality of care”.

The plurality of care method was used for groups using the GPRO web interface. Beneficiaries were attributed to a group that billed a larger share of office and outpatient E/M services (based on dollars) than any other group that the patients had seen. The beneficiaries also had to have had at least two E/M services at that group. This method was used for both the GPRO quality measures and for the per capita cost measures. **CMS seeks comments whether to continue using this method for the GPRO web interface or to use the method in the Shared Savings Program (slightly different but still based on plurality of care for primary care services).**

CMS proposes to use the same attribution method (plurality) that is finalized for GPRO web interface for PQRS also for purposes of the value-based payment modifier. That is, CMS would calculate the per capita cost measures based on the same attributed patient population for all groups of physicians that report PQRS quality data, whether through claims, registry, EHR or the administrative claims-based option. This needs clarification because elsewhere in the proposed rule CMS indicates that groups can report quality measures under GPRO using claims, registry or EHR without having beneficiaries attributed to the group.

CMS goes on to say that they are concerned that this plurality method would be too restrictive since it relies solely on E/M visits and would, for some groups, fail to identify beneficiaries for whom the group provides services, i.e for radiologists or anesthesiologists that do not submit E/M codes. **Thus CMS seeks comments on whether to use the “degree of involvement” method for all groups except those who report quality measures using the PQRS GPRO web interface, in which case the plurality method would be used.**

Under the “degree of involvement” attribution method, patients are classified into categories for physicians who submitted at least one Part B claim for that patient:

- Directed – physician billed for 35% or more of patients office or other outpatient E/M visits
- Influenced – physician billed for less that 35% of the patient’s E/M visit but for 20% or more of the patient’s total professional costs
- Contributed – physician billed for less than 35% of the patient’s E/M visits and less than 20% of the patient’s total professional costs

Thus, in this methodology all of the patients for whom a physician billed Part B claims are attributed to the physician, but the patients are classified according to the degree of involvement. Physicians may
have patients attributed to them in more than one category. A patient can be attributed to more than one physician. Per capita cost measures are calculated for the patients within each of the categories.

Data from the 2010 Physician Feedback reports shows that physicians that “contributed” to care (most radiologists fell into this group) had on average less than one E/M visit per year with the beneficiary and on the average billed for less than 20% of the beneficiary’s total professional costs. On average, at least five physicians contributed to a beneficiary’s care (not including physicians that directed or influenced that beneficiary’s care). CMS found that about 20% of beneficiaries had care in which physicians only “contributed”, that is no care “directed” or “influenced”. CMS believes that any attribution rule should include the “contributed” beneficiaries because these cases have the greatest potential for improved care and coordination.

CMS thus proposes and seeks comments on whether to use a modified “degree of involvement” approach for patient attribution to groups for use in the value-based payment modifier. CMS proposes to use two patient populations for attribution 1) a combination of the directed and influenced rules (which would include physicians who billed for 35% of patient’s E/M visits or at least 20% of the patient’s total professional costs) and 2) the contributed rule (which would include physicians who billed less than 35% of E/M visits and less than 20% of total professional costs). Separate per capita cost measure calculations would be done for each of these two patient populations.

(f) Proposed composite scores for the value based payment modifier pg 601
By statute for purposes of the value-based payment modifier, CMS is required to base evaluation of both quality and cost on a composite of measures.

1) Proposed quality and cost domains pg 601
Quality domain
CMS proposes to classify each quality measure proposed for the value-based payment modifier into six domains that reflect priorities established in the National Quality Strategy, as was done for the EHR Incentive program:
1. Patient and Family Engagement
2. Patient Safety
3. Care Coordination
4. Population and Public Health
5. Efficient Use of Healthcare Resources
6. Clinical Processes/Effectiveness

Each domain will be weighted equally to form a quality of care composite. Within each domain, each measure will be weighted equally.

Cost domain
CMS proposes to group the five per capita cost finalized in the CY2012 Final Rule into two domains: total overall cost (one measure) and total costs for beneficiaries with specific conditions (four measures: diabetes, CAD, COPD, heart failure). CMS proposes to weight each cost domain equally to form the cost composite and weight each measure within the domains equally. If a cost measure cannot be calculated (e.g. too few cases) the remaining measures would be weighted equally.
If CMS uses the degree on involvement attribution method described above (two population groups: directed/influenced and contributed), they propose to weight the measures in each population based on the physician group’s allow charges for beneficiaries attributed.

(2) Proposed scoring methods pg 604
CMS’ intention for the composite scoring method is that the composite scores should clearly distinguish between high and low performers. CMS proposes to score a group’s performance based on difference from a national mean, measure-by-measure. For each quality and cost measure, CMS would score by taking the difference of a group’s measure performance rate and the benchmark rate (national mean on the measure) and then dividing that by the measure standard deviation. Thus each measure would have a standard score. The average of measure scores in each domain would give the domain standardized score.

Example of Standardized Scores in one Quality Domain (Table 69 in the rule):

<table>
<thead>
<tr>
<th>Group Performance Rate</th>
<th>Benchmark (National Mean)</th>
<th>Standard Deviation</th>
<th>Standardized Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Measures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure 1</td>
<td>95.0</td>
<td>93.5</td>
<td>3.3</td>
</tr>
<tr>
<td>Measure 2</td>
<td>71.4</td>
<td>86.3</td>
<td>13.9</td>
</tr>
<tr>
<td>Measure 3</td>
<td>100.0</td>
<td>60.6</td>
<td>13.2</td>
</tr>
<tr>
<td>Quality Domain Score</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A standardized score of 0.0 would mean performance at the national mean.

(3) Proposed benchmarks and peer groups for quality measure pg 606
CMS proposes that the benchmark calculation be “unified” by weighting the performance rate of each physician or group of physicians reporting a measure by the number of cases used to calculate the performance rates. CMS believes this will take bias out of how a physician chooses to report a measure. That is, the sample size requirement for reporting by claims is 50% and 80% for registry reporting.

CMS proposes to publish the previous years’ performance rate and standardized score on each quality measure in order for groups of physicians to know what the benchmark would be for the following year.

(4) Proposed benchmarks and peer groups for cost measures pg 607
CMS proposes to use the plurality of care attribution method for groups of physician reporting PQRS quality measures regardless of reporting mechanism. CMS also proposes that the peer group for comparison of cost measure performance rates include all other groups of physicians for which the plurality of care attribution method was used.

However, CMS seeks comment on cost measure peer groups would change if the “degree of involvement” attribution methodology was used. Alternatively, CMS would like comments on establishing cost benchmarks on the basis of quality measures. So the peer group comparison for costs would be physicians or groups that reported the same quality measures. A mean per capita cost for those reporting the same quality measure would be the benchmark. This encourages selection of quality measures that more accurately reflect practice patterns.

Although CMS is not proposing use of episode-based costs in this rule, they believe the scoring methods described can be used for identifying high and low outliers relative to benchmarks for episodes of care.
For example, an episode cost profile for a patient with macular degeneration. In using episode cost based measures, stratifying patients by relevant condition-specific characteristics would be a useful attribution method. **CMS seeks comments on this approach in the future.**

**(5) Proposed reliability standard pg 608**

To address statistical reliability of a measure, CMS propose to establish a minimum number of cases in order for a quality or cost measure to be included in its composite. If a physician group does not report the minimum threshold for a measure, that measure will not be counted in the domain, with the remaining measures in the domain having equal weight. In the case where no measures were reported that reached the threshold (no reliable domain information), CMS would not calculate the value-based payment modifier and payment would not be affected. CMS proposes a threshold of 20 cases for both quality and cost measures to ensure reliability. CMS believes that data from the 2010 Physician Feedback report supports this proposal. Experience from that report shows that for individual physician’s reliability was higher when the minimum case size was 20 or more. CMS believes the reliability will increase when evaluating at the TIN vs NPI level. **CMS seeks comments on the proposed reliability threshold.**

g. **Proposed payment adjustment amount pg 610**

As stated in an earlier section of the rule (overview of the value-based payment modifier on pages 8 and 9 of this document), CMS intends to balance compliance with legislation and giving itself and the physician community experience with the value-based payment modifier before setting substantial payment adjustments both downwards and upwards. Additionally, CMS recognizes that there are two other payment adjustments potentially affecting physician reimbursement in 2015 and 2016: 1) the PQRS payment adjustment, -1.5% and -2.0% respectively, and 2) the EHR Incentive program adjustments of -1.0% in 2015 (or -2% if the physician is subject to the eRx penalty), -2% in 2016 and 3% in 2017.

Thus, as summarized above, CMS proposed:

1. Groups that have satisfactorily reported PQRS quality measures data for 2013/2014 incentives or satisfactorily reported using the administrative claims-based mechanism. For the 2015/2016 payment adjustment CMS proposes to set the initial value based payment modifier at 0.0% for these groups of physicians, thus payments would not be affected.

   These groups would have the option for the value based modifier to be calculated using a quality-tiering approach with the opportunity to earn an upward payment adjustment for high performance (high quality/low cost) and to be at risk for downward adjustment for poor performance (low quality/high cost). The exact amount of the upward payment adjustment cannot yet be determined because of the budget-neutrality requirement and a proposed downward limit of -1.0% initially.

2. Groups that have not met the PQRS satisfactory reporting criteria, including groups that have decided not to participate in any PQRS reporting mechanism. Without the PQRS quality data to assess quality of care, CMS proposes to set the 2015 value based payment modifier for these groups to -1.0 (more detail below). This negative adjustment would be in addition to the -1.5% payment adjustment for failing to meet the satisfactory reporting criteria under PQRS.

*h. Proposed value-based payment modifier scoring methodology pg 613*
This section discusses CMS’ proposals for comparing quality and cost for groups that request their value-based payment modifier be calculated using the quality-tiering approach.

CMS proposes two models that compare quality/cost: 1) quality tier and 2) total performance score.

1) **Quality tiering**
This model compares the quality composite with the cost composite by classifying the quality composite scores into high, average and low categories based on statistical variation from the mean quality composite score. CMS believes this will show meaningful differences between high and low performers, assessed as performance scores with at least one standard deviation from the mean, at a 5.0% level of significance. **CMS seeks comments on this proposal as well as whether they should only assess differences that are at least two or three standard deviations from the mean. CMS also seeks comments as to whether to define the high and low categories as a fixed percentage, e.g. 2.5% of the number of groups of physicians or of the amount of payments under the PFS. This would minimize the number of groups subject to payment adjustment (downward and upward?).**

Using similar methodology, CMS proposes to classify groups of physicians into high, average, and low cost categories based on whether they are significantly above, not different from, or below mean cost composite scores. CMS proposes to assess meaningful differences as those performance scores that are at least one standard deviation from the mean and to assess precision at the 5.0 percent level of significance. **CMS seeks comments on these proposals and whether they should also consider the options described for the quality of care composite for the cost composite score (assessing only two or three standard deviations or using a fixed percentage).**

The table below from the rule shows CMS options for the quality-tiering approach. CMS proposes to establish the upward payment adjustment factor (“x”) after the performance period has ended based on the aggregate amount of downward payment adjustments. For example, CMS states they could calculate that the payment adjustment factor (“x”) would be 0.75 such that high quality/low cost groups of physicians would receive a 1.5 percent (2 x 0.75) upward payment adjustment during the payment adjustment period.

<table>
<thead>
<tr>
<th>TABLE 70: Value-Based Payment Modifier Amounts for the Quality-Tiering Approach</th>
<th>Low cost</th>
<th>Average cost</th>
<th>High cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality/cost</td>
<td>High quality</td>
<td>+2.0x*</td>
<td>+1.0x*</td>
</tr>
<tr>
<td></td>
<td>Average quality</td>
<td>+1.0x*</td>
<td>+0.0%</td>
</tr>
<tr>
<td></td>
<td>Low quality</td>
<td>+0.0%</td>
<td>-0.5%</td>
</tr>
</tbody>
</table>

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

CMS also proposes an additional incentive for groups to furnish care to high-risk Medicare beneficiaries to ensure that the payment modifier does not cause unintended consequences of high-risk patient deselection by groups. CMS proposes that the scoring methodology provide a greater upward payment adjustment (+1.0x) for groups that care for high-risk patients (using average HCC risk score of the attributed beneficiary population) and submit data on PQRS quality measures through any PQRS GPRO mechanism. Specifically, CMS proposes to increase the upward payment adjustment from +2x to +3x for groups classified as high quality/low cost and from +1x to +2x for groups that are either high
quality/average cost or average quality/low cost if the groups’ attributed patient population has an average risk score in the top 25 percent of all beneficiary risk scores. CMS is not proposing this additional upward payment adjustment of +1.0x for groups that select the PQRS administrative claims-based reporting option.

(2) Total performance score pg 617
CMS believes that the total performance approach allows them to develop a unique value-based payment modifier for each group and results in a range of continuous payment adjustments rather than the thresholds proposed in the quality tier approach. CMS would calculate a total performance score (TPS) by equally weighting the quality of care and cost composites. A negative score for the quality composite means the group performed below the national average on the relevant quality measures and a negative score for the cost composite means the group of physicians had higher costs than the national average. A score of zero means the group performed at the national average. CMS would develop an exchange function in which they translated the total performance score into a unique value-based payment modifier for each group. This method is similar to the approach CMS uses in the Hospital Value-Based Purchasing program which uses a linear exchange function to develop a unique payment for each hospital.

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Quality Composite (50%)</th>
<th>Cost Composite (50%)</th>
<th>TPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 2</td>
<td>-.9</td>
<td>-.2</td>
<td>-1.2</td>
</tr>
<tr>
<td>Group 3</td>
<td>2.2</td>
<td>1.2</td>
<td>1.70</td>
</tr>
</tbody>
</table>

CMS believes the quality-tiering approach may better compare the quality of care furnished to costs and that this approach is more transparent. They seek comments on whether to use the quality-tiering or the total performance score methodology, as well as what weights should be given to the quality and cost composites for the total performance score methodology.

(i) Proposed informal review and inquiry process pg 618
The statute provides that there shall be no administrative or judicial review or otherwise of the following: the establishment of the value-based payment modifier, the evaluation of the quality of care composite, the evaluation of costs composite, the date of implementation of the modifier, the specifications of the performance periods, the application of the payment modifier, and the determination of costs.

CMS believes that a mechanism is needed for groups to review and to identify any possible errors prior to application of the value-based payment modifier. Thus, CMS intends to disseminate Physician Feedback reports containing CY 2013 data in the fall of 2014; these reports would be the basis of the value-based payment modifier in 2015. CMS proposes that these reports would contain the quality and cost measures, and measure performance and benchmarks used to score the composites, and quality of care and cost composite scores, and the value-based payment modifier amount.

After the dissemination of these reports, CMS proposes that physicians would be able to e-mail or call a technical help desk to inquire about their report and the calculation of the value-based payment modifier. CMS notes that groups of physicians will also be able to use the informal review process for the PQRS payment adjustment.
This section of the proposed rule provides an example for a group of physicians that satisfactorily reports quality measures through the PQRS GPRO web-interface and elects to have the value-based payment modifier calculated using the proposed quality-tiering methodology.

4) Physician Feedback Program pg 622

In September 2011, CMS disseminated feedback reports to physicians that participated in the PQRS GPRO and in March 2012 CMS produced and made available reports to 23,000+ physicians practicing in Iowa, Kansas, Missouri, and Nebraska. Information about the methodologies used and the aggregate findings from these reports is available at [http://www.cms.gov/physicianfeedbackprogram](http://www.cms.gov/physicianfeedbackprogram).

The March 2012 (based on 2010 data) reports contained two sets of quality measures: 1) PQRS measures reported by physicians using the claims and 2) 41 quality measures calculated by CMS from administrative claims data alone. About 25% of the physicians reported one or more PQRS measures (average was 3.7 measures) in 2010. The five specialties with the highest participation rates were ophthalmology, anesthesiology, gynecology/oncology, pathology and geriatric medicine.

The performance rates for these PQRS measures were strongly skewed upward. For about ¾ of the measures, the 50% percentile was 100%. For the administrative claims-based measures, a physician’s report included information for any beneficiary to whom the physician furnished at least one service even if the physician did not provide treatment indicated by the quality measure. So radiologists would see performance rates for diabetes management or mental health care.

The March 2012 reports also provided information on five per capita cost measures (total per capita for beneficiaries attributed to the physician and total per capita costs for four chronic conditions). These were discussed earlier. CMS used the “degree of involvement” attribution method in these reports. CMS highlights two points from these reports: 1) primary care physicians generally provided services to fewer patients than surgeons/specialists and other “types of physicians (which included radiologists, anesthesiologists, and pathologists) and primary care physicians “directed” care more often, and 2) that several physician types in all categories who only “contributed” to care, meaning that care is frequently fragmented, highlighting the importance of coordination.

Physician Feedback dissemination strategy pg 635

CMS learned that the overwhelming factor that prevents physicians from accessing their reports is lack of knowledge about their availability (31% of the March 2012 reports were actually accessed by the physicians – up from 1% of previous versions!). CMS has worked with stakeholders to increase physician awareness and intends to increase their outreach. CMS summarizes their future plans for the Physician Feedback Reports.

- Fall 2012. CMS plans to disseminate reports to all physicians in nine states (California, Iowa, Illinois, Kansas, Michigan, Minnesota, Missouri, Nebraska, and Wisconsin) based on 2011 data. They also plan to disseminate reports to groups that reported measures through the PQRS GPRO web interface in 2011.
- Fall 2013. CMS plans to disseminate reports at the TIN level to all groups of physicians with 25 or more eligible professionals and to individual physicians that satisfactorily reported measures through PQRS in 2012. CMS intends to include a preliminary look at the methodologies that are proposed for the value-based payment modifier. CMS also plans to include some episode-based cost measures.
Fall 2014. CMS plans to disseminate reports based on 2013 data that show the amount of the value-based payment modifier and the basis for its determination. CMS plans to provide these reports to all groups at the TIN level with 25 or more eligible professionals. CMS is examining whether they can provide reports to groups with fewer than 25 eligible professionals and to individual physicians.