2013 Medicare Physician Fee Schedule Final Rule Summary

On Nov. 16, 2012, CMS released the 2013 Medicare Physician Fee Schedule Final Rule. Unless otherwise specified, provisions of this final rule are effective on Jan. 1, 2013. CMS revised payment policies under the Medicare physician fee schedule (PFS) and made other policy changes related to Medicare Part B payment, applicable to services furnished in calendar year (CY) 2013.

The final rule provides updates to physician incentive programs, including the Physician Quality Reporting System (PQRS) and the electronic prescribing (eRx) program. The rule also includes additional details for implementing the value-based payment modifier required by the Patient Protection and Affordable Care Act (PPACA) that will affect physician payments based on quality and cost of care furnished to Medicare beneficiaries. Other items of interest for gastroenterologists include a new gastroenterology PQRS measure, "*Endoscopy and Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients*," for claims and registry reporting.

Payment Policy Provisions

Payment Update

In the absence of Congressional action, an overall reduction of 26.5 percent will be imposed in the conversion factor used to calculate payment for physicians' services on or after Jan. 1, 2013, due to the sustainable growth rate (SGR) formula. The conversion factor for CY 2103 will be $25.0008.

By law, CMS is required to make these reductions, which can only be averted by an act of Congress. While Congress has provided temporary relief from these reductions every year since 2003, a long-term solution is critical. The AGA understands and appreciates the concerns about government spending, but believes steps must be taken to protect and strengthen the Medicare program. We support CMS in its call to Congress to fix the current SGR formula. Before access to care is further threatened for the millions of patients who depend on the Medicare program, Congress must replace the SGR formula with a stable and equitable payment mechanism that reflects the costs of caring for Medicare beneficiaries and ensures access to high-quality care. AGA, along with all of organized medicine, will continue to advocate for a permanent solution to the broken payment system that provides fair, equitable and predictable reimbursement to physicians.

To help you better understand the impact of these cuts to your practice, AGA has prepared a payment analysis for GI codes paid under the physician fee schedule, which details payment rates with the 26.5 percent reduction. In addition, we have included an analysis of what payments would be if Congress mandates a short-term fix with a payment freeze.

Potentially Misvalued Codes

Bundling and Episodes of Care. CMS is required by Congress, as part of the Middle Class Tax Relief and Job Creation Act of 2012, to conduct a study that would examine options for bundled or episode-based payment to cover physicians' services currently paid under the PFS for one or more prevalent chronic conditions or

episodes of care for one or more major procedures, which would be due by Jan. 1, 2013. In response to the mandate, CMS stated it had consulted with medical professional societies, private payors, health-care system administrators and other stakeholders; met with other CMS staff involved in other bundling initiatives; and performed an extensive literature review. CMS will continue to examine options for bundled or episode-based payments and will include its recommendations and implementation options in its report to Congress. Following completion of this report, CMS will look to work with interested stakeholders in testing bundling concepts within the PFS.

Improving the Valuation of the Global Surgical Package. CMS asked for comments on methods of obtaining accurate and current data on evaluation and management (E/M) services furnished as a part of the global surgical package. Several commenters stated that the global payment methodology has restricted CMS' ability to audit the accuracy of the current value of services, as well as the accuracy of the AMA/Specialty Society Relative Value Scale Update Committee (RUC) recommendations for services with a global period. Commenters recommended that CMS establish auditable documentation requirements for inpatient and outpatient post-operative visits. Other commenters suggested that CMS adjust all surgical services to a zero day global period, require surgeons to bill post-operative E/M services separately for payment purposes, and subject those billings to the same coding and documentation standards and audits to which other practitioners are already subject. Still others stated that they believe post-operative work is appropriately surveyed, vetted and valued by the AMA RUC during its ongoing reviews of surgical procedures, and therefore, claims-based reporting is unnecessary to verify that the number of visits assigned to global surgical procedures is accurate. CMS thanked commenters for their recommendations and stated it would carefully weigh all comments received as CMS considers how best to measure the number and level of visits that occur during the global period.

Review of Codes with Annual Charges of $10 Million or More. CMS proposed reviewing Harvard-valued services with annual Medicare-allowed charges of $10 million or greater. While the current procedural terminology (CPT) codes meeting these criteria have relatively low Medicare utilization (as CMS has reviewed the services with utilization greater than $30,000), they account for significant Medicare spending annually and have never been reviewed. Among the codes is 43264: *Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts*, which is scheduled for review by CMS for CY 2014.

The GI societies are committed to working within the AMA RUC process to ensure gastroenterology endoscopy codes are accurately and fairly valued. The societies are preparing for a coding change submission to the CPT editorial panel for codes 43260-43272, including code 43264. Pending the recommendations of the CPT editorial panel, the GI societies expect to survey this code and submit recommendations to the AMA RUC during 2013.

Expanding the Multiple Procedure Payment Reduction (MPPR) Policy. CMS adopted its proposal to apply an MPPR to the technical component of diagnostic cardiovascular and ophthalmology services, but is also soliciting comments on whether the MPPR should be applied to the technical component of all diagnostic tests, rather than just imaging procedures. The Medicare Payment Advisory Commission (MedPAC) examined Part B claims data from 2010 to look for diagnostic tests that are frequently furnished more than once on the same day by the same physician for the same beneficiary.

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MedPAC found that several surgical pathology codes are frequently billed with more than one unit of service on the same date. For example, one-third of the claims for CPT code 88305 (*Level IV, surgical pathology, gross and microscopic examination*) contained more than one unit of service for that code. In these cases, it appeared that the same pathologist examined multiple specimens from the same beneficiary at the same time. MedPAC indicated that CMS should analyze whether there are efficiencies in practice expense or physician work that occur when multiple units of the same test are performed at the same time. If so, MedPAC suggested that CMS should consider applying the MPPR policy to these services or creating bundled codes that include multiple units of the same test. MedPAC noted that these services account for a substantial and growing amount of Medicare spending; in 2010, Medicare spent $1.3 billion on CPT code 88305.

High-Volume Codes — CPT Code 88305. In the final rule, CMS lowered the technical component (TC) of the surgical pathology code 88305 by 52 percent, although it raised the professional component (PC) by 2 percent beginning Jan. 1, 2013. This change alters the global payment for this code, which will decrease by 33 percent as a result of this revaluation. As directed by the health-care reform law, CMS has been evaluating high volume codes from all specialties as potentially overvalued services. CPT code 88305 is not only high volume, but its TC has not been reviewed since initially valued in 2000. An analysis posted on the AGA website provides the estimated payment amount for CPT code 88305. CMS initially proposed to reduce payment for CPT code 88305 by 1 percent.

Review of Services with Stand Alone Practice Expense (PE) Procedure Time. CMS finalized a proposal to adjust procedure time based on educational materials they reviewed that noted a decrease in procedure time, which sets a new precedent for how the agency adjusts procedure time. In the CY 2012 PFS final rule, CMS received and accepted PE recommendations from the AMA RUC for two radiation therapy codes. However, CMS was later notified that discrepancies between the procedure time assumptions used in establishing non-facility PE relative value units (RVUs) for these services and the procedure times made widely available to Medicare beneficiaries and the general public existed. Specifically, the direct PE inputs for one of the radiation therapy codes reflected a procedure time assumption of 60 minutes; however, information available to Medicare beneficiaries and the general public indicated that the radiation therapy session typically last between 10 and 30 minutes. The other radiation therapy code reflected a procedure time assumption of 90 minutes; however, information available to Medicare beneficiaries and the general public stated the treatment typically lasted no longer than 60 minutes. As a result, CMS finalized its proposal to adjust the procedure time assumptions for the treatment codes to 30 minutes and 60 minutes, respectively. Many commenters disagreed with CMS' proposal to adjust the procedure time assumptions for these services. Commenters stated that publicly available procedure time information does not consider the time resources required prior to or following the procedure and that educational information for patients is an inappropriate data source because such material is not subject to the same degree of scrutiny by the medical community as the information presented to the AMA RUC.

Procedures Subject to the Hospital Outpatient Prospective Payment System (OPPS) Cap. CMS proposed to add codes to the list of procedures subject to the OPPS cap, effective Jan. 1, 2013. Some of the codes are replacement codes for codes deleted for CY 2013. The procedures proposed for addition to the list meet the definition of imaging under section 5102(b) of 173 the Deficit Reduction Act and are being added on an interim final basis. The addition of the codes as procedures subject to the OPPS cap would be open to public comment. Of interest to GI are CPT codes 91110 (*GI tract capsule endoscopy*) and 91111 (*Esophageal capsule endoscopy*).

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New Code – HCPCS G0455

The CPT Editorial Panel created CPT code 44705 (*Preparation of fecal microbiota for instillation, including assessment of donor specimen*) for CY 2013. The AMA RUC recommended a work RVU of 1.42, which is a direct crosswalk to CPT code 99203 *(Level 3 office or other outpatient visit, new patient*). This service is currently (CY 2012) reported under CPT code 44799 (*Unlisted procedure, intestine*), as is the instillation of the microbiota. Within Medicare, payment for the preparation of the donor specimen would only be made if the specimen is ultimately used for the treatment of a beneficiary as Medicare is not authorized to pay for any costs not directly related to the diagnosis and treatment of a beneficiary. Because of this policy, CMS believes it is appropriate to bundle the preparation and instillation into one payable health-care common procedure coding system (HCPCS) code. For CY 2013, CMS created HCPCS code G0455 (*Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen*). HCPCS code G0455 will replace new CPT code 44705 and will have a PFS procedure status indicator of 'I', indicating the code is not valid for Medicare purposes. This code will include both the work of preparation and instillation of the microbiota. Therefore, on an interim final basis for CY 2013, CMS is assigning a total RVU of 3.55 to HCPCS code G0455.

Geographic Practice Cost Indices (GPCIs)

CMS did not propose, or subsequently finalize, any changes to the data or methodology used to calculate the work geographic price cost indices (GPCI) for CY 2013. CMS stated it would propose updates next year. However, CMS reminded the public that the statutory 1.0 work graphic pricing cost index (GPCI) floor would expire on Dec. 31, 2012. CMS further noted it did not have the statutory authority to extend the 1.0 work GPCI floor beyond the Dec. 31 expiration date.

Medicare Telehealth Services for the Physician Fee Schedule

CMS finalized the addition of intensive behavioral therapy for obesity, reported by HCPCS code G0447 (*Face-to-face behavioral counseling for obesity, 15 minutes*), to the list of telehealth services for CY 2013.

Extension of Payment for Technical Component of Certain Physician Pathology Services

Last year, CMS finalized its policy that an independent laboratory may not bill a Medicare contractor for the TC of physician pathology services furnished after Dec. 31, 2011, to a hospital inpatient or outpatient. Subsequent to the rule, Congress acted to continue payment to independent laboratories through June 30, 2012. CMS finalized conforming changes such that CMS would continue payment under the PFS to independent laboratories furnishing the TC of physician pathology services to fee-for-service Medicare beneficiaries who are inpatients or outpatients of a covered hospital on or before June 30, 2012. Independent laboratories may not bill the Medicare contractor for the TC of physician pathology services furnished after June 30, 2012, to a hospital inpatient or outpatient.

Primary Care and Care Coordination

CMS continues to explore refinements to the PFS that would appropriately value primary care and care coordination. Since the care coordination included in many E/M services does not adequately cover the significant non-face-to-face care management work involved, the agency is implementing new options to recognize the additional resources involved in furnishing coordinated care. In addition, CMS is exploring the idea of advanced primary care through practices certified as medical homes in the fee-for-service setting.

Post-Discharge Care Management Services. For CY 2013, CMS proposed to create a new HCPCS G code to describe post-discharge transitional care management (TCM) services. Commenters in support of the proposal suggested that CMS adopt the AMA's new CPT TCM codes in place of its proposed TCM G code. CMS agreed

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with those commenters, and therefore, finalized that it would pay for the new CPT TCM codes 99495 and 99496 with some small modifications to the code descriptions developed by the AMA. CMS finalized the following requirements of the CPT TCM codes for Medicare purposes in the final rule.

CPT TCM Code	Requirements
99495, Transitional Care Management Services	• Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge. • Medical decision making of at least moderate complexity during the service period. • Face-to-face visit, within 14 calendar days of discharge.
99496, Transitional Care Management Services	• Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge. • Medical decision making of high complexity during the service period. • Face-to-face visit, within seven calendar days of discharge.

CMS stated that any physician who is appropriately enrolled in Medicare and furnishes the service might bill for that service. The agency confirmed that, while it expected the TCM codes to be billed most frequently by primary care physicians, specialists who furnish the requisite services in the code descriptions would also be able to bill the new TCM codes. CMS noted its belief that there will be circumstances in which cardiologists, oncologists or other specialists would be in the best position to furnish transitional care coordination after a hospital discharge.

CMS finalized that transitional care management requires a face-to-face visit, initial patient contact and medication reconciliation within specified time frames. The first face-to-face visit is part of the transitional care management service and not reported separately. Additional E/M services after the first face-to-face visit may be reported separately. Transitional care management requires an interactive contact with the patient or caregiver, as appropriate, within two business days of discharge. The contact may be direct (face-to-face), telephonic or by electronic means. Medication reconciliation and management must occur no later than the date of the face-to-face visit.

Medical decision-making and the date of the first face-to-face visit should be used to select and report the appropriate transitional care management code. For 99496, the face-to-face visit must occur within seven calendar days of the date discharge and medical decision-making must be of high complexity. For 99495, the face-to-face visit must occur within 14 calendar days of the date of discharge and medical decision-making must be of at least moderate complexity.

CMS finalized that only one individual may report these services and only once per patient within 30 days of discharge, and that the same individual or group for any subsequent discharge(s) could not report another transitional care management service within the 30 days. However, CMS finalized that the same individual may report hospital or observation discharge services and transitional care management, but should not report transitional care management services provided in the post-operative period for a service with a global period.

Primary Care Services Furnished in Advanced Primary Care Practices. In the proposed rule, CMS discussed the possibility of establishing enhanced payments for care coordination activities inside of an advanced primary care practice (i.e., medical home) and invited comment on how Medicare would recognize and pay for those services. CMS stated its belief that targeting primary care management payments to

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advanced primary care practices could have many merits, including ensuring a basic level of care coordination and care management. CMS recognized that the advanced primary care model has demonstrated efficacy in improving the value of health care in several contexts, and CMS would be exploring whether it could achieve those outcomes for the Medicare population through several demonstration projects. CMS received many helpful and informative comments on the issues it discussed in relation to recognizing advanced primary care practices, especially on the criteria and processes that should be used to identify such practices. CMS stated it was actively considering such an advanced primary care practice model in the near future after a complete assessment of the results of ongoing demonstrations and policy and operational considerations.

Payment for Molecular Pathology Services

CMS proposed to price all of the 101 new molecular pathology codes through a single fee schedule, either the clinical laboratory fee schedule (CLFS) or the PFS. The agency decided that molecular pathology CPT codes described clinical diagnostic laboratory tests and should be paid under the CLFS because these services did not ordinarily require interpretation by a physician to produce a meaningful result. CMS also stated that it did believe that, in some cases, a physician interpretation of a molecular pathology test may be medically necessary to provide a clinically meaningful, beneficiary-specific result. Therefore, to make PFS payment for that physician interpretation, CMS created HCPCS G code G0452 (*Molecular pathology procedure; physician interpretation and report*) to describe medically necessary interpretation and written report of a molecular pathology test, above and beyond the report of laboratory results, on an interim basis for CY 2013. CMS stated that the professional component-only HCPCS G code will be considered a "clinical laboratory interpretation service," which is one of the current categories of PFS pathology services under the definition of physician pathology services. According to CMS, the current CPT code for interpretation and report, 83912-26, which is included on the current list of clinical laboratory interpretation services, would be deleted at the end of CY 2012. CMS stated it would monitor the utilization of this service and collect data on billing patterns to ensure that G0452 is only being used when interpretation and report by a physician is medically necessary and is not duplicative of laboratory reporting paid under the CLFS.

Payment for New Preventive Services HCPCS G Codes

A number of preventive services were newly covered in CY 2012 as a result of CMS' new authority under PPACA to add coverage for additional preventive services if certain statutory criteria are met as determined through the national coverage determination process. Among the newly covered services is G0447 (*Face-to-face behavioral counseling for obesity, 15 minutes*), which was effective Nov. 29, 2011, and priced by Medicare contractors since values and inputs had not been assigned.

Certified Registered Nurse Anesthetists (CRNA) Scope of Benefit

CMS finalized its proposal with modification to revise its regulations to define "anesthesia and related care" under the statutory benefit for CRNA services as follows: "anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished." CMS noted it would continue to monitor the state scope of practice laws for CRNAs in order to insure that the use of state scope of practice as a proxy to define "anesthesia services and related care" is consistent with the goals and needs of Medicare program.

Ordering of Portable X-Ray Services

CMS finalized its proposal to revise the Medicare conditions for coverage to permit portable x-ray services to be ordered by physicians or nonphysician practitioners in accordance with the general ordering policies for

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other diagnostic services. Effective for services furnished on or after Jan. 1, 2013, the following practitioners will be permitted to order portable x-rays in accordance with Medicare regulations and subject to their scope of practice under state law and their applicable Medicare statutory benefit: a physician (including an MD or DO, doctor of optometry, doctor of dental surgery, doctor of dental medicine, and doctor of podiatric medicine), or a nurse practitioner, clinical nurse specialist, physician assistant, certified nurse-midwife or clinical psychologist, where the ordering of portable x-ray services is within the scope of their practice under state law. CMS will monitor ordering patterns for portable x-ray services to determine if additional activities are needed to prevent abuse of this service.

Part B Drug Payment: Average Sales Price (ASP) Issues

CMS finalized its proposal to maintain the threshold for the widely available market price (WAMP) and the average manufacturer price (AMP) at 5 percent. In light of recent concerns about drug shortages, CMS proposed it would prevent the AMP price substitution policy from taking effect if the drug and dosage form represented by the HCPCS code are reported by the FDA on their current drug shortage list (or other FDA reporting tool that identifies shortages of critical or medically necessary drugs) to be in short supply at the time that ASP payment limits were being finalized for the next quarter.

Technical Correction — Waiver of Deductible for Surgical Services Furnished on the Same Date as a Planned Screening Colorectal Cancer Test and Colorectal Cancer Screening Test Definition

In accordance with its statutory mandate, CMS previously proposed and finalized, in the CY 2011 PFS, that "all surgical services furnished on the same date as a planned screening colonoscopy, planned flexible sigmoidoscopy, or barium enema be considered to be furnished in connection with, as a result of, and in the same clinical encounter as the screening test." CMS failed, however, to update its regulations to reflect this policy.

In the CY 2013 PFS proposed rule, CMS proposed to amend its regulations to include colorectal screening tests that become diagnostic services in the list of services for which the deductible does not apply. CMS also stated its belief that the intent of PPACA was to waive the deductible for tests that are scheduled and begin as colorectal screening tests, but that become diagnostic in the course of the treatment, so that even though the test is no longer considered and billed as a screening test, the deductible is nonetheless waived as it would have been if the test had remained a screening test.

Regarding whether the deductible would be applied to payments for anesthesia and biopsy services, CMS stated that when a colorectal screening test is furnished, the payment for moderate sedation would be included in the payment for the procedure, and there would be no associated pathology service. The deductible would be waived for these tests. As a result, the deductible would be waived for the typical sedation furnished in connection with a colorectal screening test (since it is included within the code) and there would be no need to waive any deductible for a pathology service. The proposed regulation would apply the same policy to colorectal screening tests that become diagnostic. To the extent that moderate sedation is included in a procedure that is billed with the PT modifier, the beneficiary would pay no deductible. When a beneficiary receives anesthesia other than moderate sedation with a colorectal screening test, a separate charge would be incurred to which the deductible applies. The proposed regulation would specify that same policy for screening tests that become diagnostic.

CMS also believed that the language of the PPACA is consistent with applying the deductible to pathology

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services. By the use of the term a "colorectal screening test regardless of the code that is billed," the statute waived the deductible for procedures that, in and of themselves, begin as colorectal screening tests. As noted above, pathology services would not be part of a colorectal screening test.

Quality Provisions

CMS finalized changes to the quality reporting initiatives associated with Medicare physician fee schedule payments.

Physician Quality Reporting System

Definition of Group Practice. CMS finalized its proposal to modify the definition of a group practice as "a single Tax Identification Number (TIN) with two or more eligible professionals, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN." CMS believes that changing the definition of a group practice from 25 or more to two or more will allow smaller group sizes to participate in the PQRS Group Practice Reporting Option (GPRO) and will lead to greater program participation overall.

Election Requirement for Group Practices Selected to Participate in the GPRO. CMS previously established the process for group practices to be selected to participate in the GPRO. In this rule, CMS finalized additional processes, such as accepting GPRO self-nomination statements via the web for 2013 and beyond. CMS also extended the deadline to self-nominate to Oct. 15.

*Penalties***.** Eligible professionals who do not satisfactorily report data on quality measures under the PQRS are subject to the following payment adjustments:

- 2015: -1.5 percent
- 2016 and subsequent years: -2 percent

Reporting Periods for the PQRS Payment Adjustments. CMS previously established 2013 as the reporting period for the 2015 payment adjustment for both group practices and for individual professionals. To parallel the reporting periods for the 2013 and 2014 PQRS incentives, CMS finalized both six- and 12-month reporting periods occurring two years prior to the 2015 and 2016 PQRS payment adjustments (e.g., Jan. 1, 2014, — Dec. 31, 2014, or July 1, 2014 — Dec. 31, 2014, for the 2016 adjustment). The six-month period would apply only to individual eligible professionals reporting measures groups via registry. CMS acknowledged concerns that the six-month reporting period may not capture quality as accurately as the 12-month period, but its desire to align the reporting periods of the 2013 and 2014 PQRS incentive and 2015 and 2016 PQRS payment adjustments outweigh these concerns. For 2017 and beyond, CMS finalized a 12-month reporting period for payment adjustments, eliminating the six-month reporting period.
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Criteria for Satisfactory Reporting for the 2015 and 2016 Payment Adjustments for Eligible Professionals and Group Practices using the Claims, Registry, EHR and GPRO Web Interface Reporting Mechanisms. In response to widespread support for less stringent criteria, CMS finalized the reporting of one measure for individuals and group practices, or one measures group for individuals only, using the claims, qualified registry or EHR-based reporting mechanism to avoid the 2015 PQRS payment adjustment. Since CMS did not finalize the claims-based reporting option for group practices or the EHR reporting option for groups until 2014, it will allow group practices to satisfy the one measure reporting option using registries or the GPRO Web Interface (an

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option not available to individuals) to avoid the 2015 PQRS adjustment. CMS did not finalize the one measure criteria for the 2016 payment adjustment and intends to revisit whether it should establish more stringent reporting criteria beginning with the 2016 payment adjustment.

In summary, professionals and group practices have three options for avoiding the 2015 PQRS payment adjustment:

- Meet the criteria for the 2013 PQRS incentive.
- Report one applicable measure (for individuals and group practices) or one measures group (for individuals only).
- Elect to be analyzed under the administrative claims-based reporting mechanism.

Professionals and group practices have one option for avoiding the 2016 PQRS payment adjustment — meet the criteria for satisfactory reporting for the 2014 PQRS incentive.

Requirement for Electing to Use the Administrative Claims-Based Reporting Mechanism for the 2015 Payment Adjustment. For the 2015 payment adjustment, professionals will have until Oct. 15 of the applicable reporting year to elect to use the administrative claims mechanism, which must be completed via the web. Group practices can make this election under its self-nomination statement.

Reporting Mechanisms

Group Practice PQRS Reporting Mechanisms. In 2012, group practices could only report PQRS measures through the GPRO Web Interface. Beginning in 2013, group practices can report data on quality measures using the registry reporting option and in 2014, EHR-based reporting mechanisms will be available. CMS initially offered to extend the claims reporting options to group practices, however the agency discovered after offering the proposal, that it is not technically feasible to accept group practice reporting data via the claims-based reporting mechanism at this time, but noted it would work to provide this mechanism in the future.

Administrative Claims Reporting Mechanism. For the 2015 payment adjustment, CMS finalized a new administrative claims reporting mechanism. Under this new option, a professional or group practice would not be required to submit quality data codes (QDCs) on claims to CMS for analysis. Rather, CMS would analyze every professional's or group practice's Medicare claims to determine whether the professional or practice performed any of the clinical quality actions indicated in a designated set of PQRS quality measures over a specified reporting period. CMS views this as a temporary reporting mechanism to ease professionals into reporting PQRS measures, and while it may consider it for the 2016 PQRS payment adjustment, it is not finalizing the proposal beyond 2015 at this time. Those electing to use this mechanism would be required to report a list of measures for 100 percent of the cases in which the measure applies.

Incentives

Criteria for Satisfactory Reporting for Individual Eligible Professionals for the 2013 and 2014 Incentives. For 2013 and 2014, professionals who satisfactorily report data on PQRS quality measures are eligible for an incentive equal to 0.5 percent of total estimated Medicare Part B allowed charges during the applicable reporting period. These are the last two incentives authorized under PQRS. **Tables 90** and **91** below list the finalized criteria for satisfactory reporting by individual professionals for the 2013 and 2014 PQRS incentive, respectively.

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CMS also finalized its proposal to lower the minimum patient count for reporting measures groups from 30 to 20 for individuals reporting measures groups via claims and registry for the 2013 and 2014 PQRS incentives.

Table 90: Summary of Criteria for Satisfactory Reporting by Individual Eligible Professionals of Data on PQRS Quality Measures for the 2013 Incentive

Reporting Period	Measure Type	Reporting Mechanism	Proposed Reporting Criteria
Jan 1, 2013 — Dec 31, 2013*	Individual Measures	Claims	Report at least 3 measures, OR, If fewer than 3 measures apply to the eligible professional, report 1—2 measures*; AND Report each measure for at least 50% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.
Jan 1, 2013 — Dec 31, 2013	Individual Measures	Qualified Registry	Report at least 3 measures, AND Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.
Jan 1, 2013 — Dec 31, 2013	Individual Measures	Qualified Direct EHR Product	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% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.
Jan 1, 2013 — Dec 31, 2013	Individual Measures	Qualified EHR Data Submission Vendor	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% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.
Jan 1, 2013 —	Measures	Claims	Report at least 1 measures group, AND

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Dec 31, 2013	Groups		Report each measures group for at least 20 Medicare Part B FFS patients. Measures groups containing a measure with a 0% performance rate will not be counted.
Jan 1, 2013 — Dec 31, 2013	Measures Groups	Qualified Registry	Report at least 1 measures group, AND Report each measures group for at least 20 patients, a majority of which must be Medicare Part B FFS patients. Measures groups containing a measure with a 0% performance rate will not be counted.
Jul 1, 2013 — Dec 31, 2013	Measures Groups	Qualified Registry	Report at least 1 measures group, AND Report each measures group for at least 20 patients, a majority of which must be Medicare Part B FFS patients. Measures groups containing a measure with a 0% performance rate will not be counted.

* Subject to the measure applicability validation (MAV) process.

Table 91: Summary of Criteria for Satisfactory Reporting by Individual Eligible Professionals of Data on PQRS quality measures for the 2014 Incentive

Reporting Period	Measure Type	Reporting Mechanism	Proposed Reporting Criteria
Jan 1, 2014 — Dec 31, 2014*	Individual Measures	Claims	Report at least 3 measures, OR, If less than 3 measures apply to the eligible professional, report 1—2 measures*; AND Report each measure for at least 50% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.
Jan 1, 2014 — Dec 31, 2014	Individual Measures	Qualified Registry	Report at least 3 measures, AND Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.
Jan 1, 2014 — Dec 31, 2014	Individual Measures	Direct EHR product that is CEHRT	Report 9 measures covering at least 3 domains. If an eligible professional's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional must report the measures for which there is patient data.
Jan 1, 2014 — Dec 31, 2014	Individual Measures	EHR data submission vendor's product that is CEHRT	Report 9 measures covering at least 3 domains. If an eligible professional's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional must report the measures for which there is patient data.
Jan 1, 2014 — Dec 31, 2014	Measures Groups	Claims	Report at least 1 measures group, AND Report each measures group for at least 20 Medicare Part B FFS patients. Measures groups containing a measure with a 0% performance rate will not be counted.
Jan 1, 2014 — Dec 31, 2014	Measures Groups	Qualified Registry	Report at least 1 measures group, AND Report each measures group for at least 20 patients, a majority of which

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			must be Medicare Part B FFS patients. Measures groups containing a measure with a 0% performance rate will not be counted.
Jul 1, 2014 — Dec 31, 2014	Measures Groups	Qualified Registry	Report at least 1 measures group, AND Report each measures group for at least 20 patients, a majority of which must be Medicare Part B FFS patients. Measures groups containing a measure with a 0% performance rate will not be counted.

* Subject to the measure applicability validation (MAV) process.

Beneficiary Assignment Methodology and Criteria for Satisfactory Reporting on PQRS Quality Measures via the GPRO. To populate the GPRO Web Interface, CMS must first assign beneficiaries to each group practice and then from those assigned beneficiaries draw a sample of beneficiaries for the disease and patient care modules in the GPRO Web Interface. In an effort to align with the Medicare Shared Savings Program, CMS finalized the beneficiary assignment and sampling methodology used under the Medicare Shared Savings Program, which, unlike the current methodology to populate the GPRO Web Interface, requires that the beneficiary being assigned had at least one primary care service furnished by a group practice physician.

A summary of the final criteria for satisfactory reporting for group practices selected to participate in the GPRO for the 2013 and 2014 incentives are specified in **Tables 92** and **93**. (see below).

TABLE 92: Criteria for Satisfactory Reporting of Data on PQRS Quality Measures via the GPRO for the 2013 Incentive

Reporting Period	Reporting Mechanism	Group Practice Size	Proposed Reporting Criterion
12-month (Jan 1 — Dec 31)	GPRO Web interface	25-99 eligible professionals	Report on all measures included in the web interface in Table 96; AND Populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100% of assigned beneficiaries.
12-month (Jan 1 — Dec 31)	GPRO Web interface	100+ eligible professionals	Report on all measures included in the web interface in Table 96; AND Populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries.
12-month (Jan 1 — Dec 31)	Qualified Registry	2+ eligible professionals	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. Measures with a 0% performance rate will not be counted.

* Subject to the measure applicability validation (MAV) process.

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Table 93: Criteria for Satisfactory Reporting of Data on PQRS Quality Measures via the GPRO for the 2014 Incentive

Reporting Period	Reporting Mechanism	Group Practice Size	Proposed Reporting Criterion
12-month (Jan 1 — Dec 31)	GPRO Web interface	25-99 eligible professionals	Report on all measures included in the web interface in Table 96; AND Populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100% of assigned beneficiaries.
12-month (Jan 1 — Dec 31)	GPRO Web interface	100+ eligible professionals	Report on all measures included in the web interface in Table 96; AND Populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries.
12-month (Jan 1 — Dec 31)	Qualified Registry	2+ eligible professionals	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. Measures with a 0% performance rate will not be counted.
12-month (Jan 1 — Dec 31)	Direct EHR product that is CEHRT or EHR Data Submission Vendor's Product that is CEHRT	2+ eligible professionals	Report 9 measures covering at least 3 domains. If the group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is patient data.

* Subject to the measure applicability validation (MAV) process.

Measures

PQRS Quality Measures for 2013 and Beyond. To align with the proposed measure domains provided in the EHR incentive program, all proposed PQRS measures are classified against six domains based on the national quality strategy's six priorities: patient and family engagement; patient safety; care coordination; population and public health; efficient use of health-care resources; and clinical processes/effectiveness. CMS finalized the following proposals for PQRS quality measures for 2013 and beyond:

- A new gastroenterology PQRS measure, *"Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients,"* was finalized for claims and registry reporting for 2013. This measure will capture the percentage of patients aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.
- Added a measure that would recognize registry reporting and is proposed for claims and registry reporting — "Participation *by a Physician or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality."*
- Retired PQRS measure "*Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)."* CMS believes it is redundant to have an eligible professional report on whether or not s/he has adopted an EHR, when they are most likely participating in the EHR incentive program.
- A new *CG-CAHPS Clinician/Group Survey* measure available for reporting through the GPRO Web interface

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in 2013 and beyond. Since this survey measure requires a different form of data collection and analysis than the other proposed measures, CMS will administer the survey on behalf of the group practices participating in the 2013 and 2014 PQRS GPRO.

- Retained the current IBD and hepatitis C measures groups. In addition, for 2013, CMS included a new oncology group with measures related to colon cancer.

Informal Review. CMS finalized its proposal to provide a timely, written response to eligible professionals and group practices seeking an informal review of the applicability of the PQRS payment adjustment. Professionals electing to use this process must request an informal review by Feb. 28 of the year in which the payment adjustment is being applied.

Electronic Prescribing (eRx) Incentive Program

CMS established requirements for the 2013 and 2014 eRx Incentive Program in the 2012 Medicare PFS final rule. This section addresses additional final requirements.

eRx GPRO. CMS clarified that since it is changing the definition of group practice in PQRS to allow groups of 2-24 professionals to participate in PQRS as a group practice, it is doing the same for the eRx Incentive Program for the 2013 incentive and 2014 payment adjustment.

Although CMS extended the deadline for group practices to opt to participate in the PQRS GPRO to the fall of the applicable program year, for operational reasons, group practices wishing to participate in the eRx Incentive Program under the eRx GPRO for 2013 must submit its self-nomination statement by Jan. 31, 2013. CMS recognizes that these two separate deadlines may cause confusion, but had to maintain the Jan.31 deadline for the eRx Program because the 2014 6-month payment adjustment reporting period (Jan. 1, 2013– June 30, 2013) occurs prior to fall 2013. CMS will try to work with group practices so that they are aware of the applicable deadlines and procedure.

CMS also finalized a lower threshold for reporting the e-prescribing measure of 75 rather than 225. That is, to be a successful e-prescriber for the 2013 incentive, group practices comprised of 2-24 professionals that are participating in the eRx GPRO must report the e-prescribing measure at least 75 times during the applicable 12-month reporting period (Jan. 1, 2013– Dec. 31, 2013). CMS adopted the same lower threshold for the 2014 payment adjustment period.

Expanded Exemptions. In addition to the existing four circumstances under which an eligible professional can request a consideration for hardship exemption, CMS finalized the following two additional significant hardship exemption categories for the 2013 and 2014 payment adjustments:

- **Professionals or group practices who achieve meaningful use during certain eRx payment adjustment reporting periods.** To qualify under this category to avoid the 2013 and 2014 eRx payment adjustment, a professional (or every professional in a group practice participating in the eRx GPRO) must have achieved meaningful use under the EHR Incentive Program for a continuous 90-day EHR reporting period that falls within the 12-month or 6-month eRx payment adjustment reporting period or for an EHR reporting period that is the full CY.

- **Professionals or group practices who demonstrate intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology.** This exemption is limited to professionals and

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group practices that have not previously adopted CEHRT or received an incentive payment under the EHR Incentive Programs. To qualify for an exemption from the 2013 payment adjustment, these professionals would have to adopt CEHRT and demonstrate intent to participate in the EHR Incentive Program by registering for the program between Jan. 2, 2012 and Jan. 31, 2013, which is an extension from CMS original deadline of Oct. 12, 2012. For exemptions from the 2014 payment adjustment, professionals would have to adopt CEHRT and register between Jan. 1, 2013 and June 30, 2013, which aligns with the deadline for the existing significant hardship exemption categories.

CMS will use information collected from the EHR Incentive Program's registration and attestation page to exempt professionals from the 2013 and 2014 payment adjustment under these two additional significant hardship exemption categories rather than requiring professionals to request these exemptions via the web.

CMS also finalized a decision to extend the deadline for making requests under the four previously established exemptions for the 2013 payment adjustment to Jan. 31, 2013 (versus June 30, 2012).

Informal Review. For the 2012 eRx incentive and 2013 eRx incentives, professionals and group practices must submit a request via email for an informal review 90 days after the receipt of the respective feedback reports. For the 2013 and 2014 eRx payment adjustments, CMS extended the deadline so that professionals and group practices have until Feb.28, 2013 and Feb. 28, 2014, respectively, to submit a request for an informal review. CMS will provide a written response to each informal review request.

The PQRS-Medicare EHR Incentive Pilot

CMS previously established the PQRS-Medicare EHR Incentive Pilot in an effort to pilot the electronic submission of CQMs for the Medicare EHR Incentive Program and to move towards the alignment of quality reporting requirements between Stage 1 of the EHR Program and the PQRS. CMS finalized its proposal to extend this pilot to CY 2013, as well as to use attestation as a reporting method for the CQM component of meaningful use for the EHR Incentive Program. CMS is only extending the pilot to 2013 because the EHR Incentive Program Stage 2 final rule requires all professionals participating in the Medicare EHR Incentive Program that are beyond their first year of meaningful use to electronically submit CQM data.

Value-Based Payment Modifier

The most major change related to the value-based payment modifier (VBM) is the group of physicians to whom CMS will initially apply the modifier. CMS originally proposed to initially apply the modifier to all groups of physicians with 25 or more eligible professionals, but, due to public concern that many aspects of the program remain untested and in need of further development, CMS finalized that the modifier will only apply to physician group practices of 100 or more in 2013. Therefore, smaller groups of 2-99 eligible professionals will remain unaffected during the first reporting year. However, CMS is still committed to applying the modifier to all physicians by 2017, as required under statute, and encourages solo practitioners and those in small groups to participate in the PQRS now since the quality composite will likely continue to be based on PQRS data. CMS also anticipates proposing to increase the amount of payment at risk under the modifier as it gains additional experience.

Application of the Value-Based Payment Modifier

For purposes of establishing group size only, CMS finalized its proposal to define an eligible professional consistent with the PQRS (i.e., physical and occupational therapists, speech pathologists, audiologists, etc.).

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CMS did not agree with suggestions that group size be determined only by the number of physicians (MDs, DOs), noting that it would have been confusing to employ a different definition under the two programs, especially since the group's participation in the PQRS informs how they are treated under value modifier.

Despite requests that CMS allow group practices the flexibility to define themselves, CMS finalized its proposed policy to apply the VBM to the items and services billed by physicians under a single TIN. Again, CMS' goal is to align the modifier with the definition of group practice used under the PQRS and, as a result, minimize operational complexity. CMS will continue to examine whether it is possible in future years to allow for the aggregation or disaggregation of TINs in order to better reflect physician group organization, as suggested by commenters.

CMS will identify groups of physicians subject to the VBM based on a query of Medicare's Provider Enrollment, Chain, and Ownership System (PECOS) on October 15, 2013. This is the extended date by which groups of physicians can submit their self-nomination statement to select their PQRS reporting method and to elect their quality-tiering methodology. CMS will then remove any groups from this list if, based on a claims analysis, the group of physicians did not have 100 or more eligible professionals that submitted claims during the performance period.

Approach to Setting the VBM Adjustment Based on PQRS Participation and the Quality-Tiering Option

Based upon comments received and in line with CMS' goal of gradual implementation of the quality-tiering methodology, CMS finalized its proposed policy, with one modification, to categorize groups of physicians eligible for the VBM into two categories:

1) 0.0% in CY2015 or voluntary election of quality tiering approach

This category includes:

(a) Groups of physicians with 100 or more eligible professionals that have self-nominated and have met the satisfactory reporting criteria for the PQRS GPRO incentive payment. To encourage groups of physicians to participate in the PQRS GPRO, CMS also decided in the final rule to include in this category those groups that have self-nominated for the PQRS as a group and reported at least one measure;

(b) Groups of physicians with 100 or more eligible professionals that have elected the PQRS administrative claims option for CY2013.

2) Automatic value-based payment modifier of -1.0% in CY2015

This category includes groups of physicians with 100 or more eligible professionals that do not fall within either of the two subcategories described above.

Groups in the first category can either opt for no payment adjustment in CY2015 or request that their value modifier be based on the quality-tiering approach. If the latter, CMS will use the performance rates on the quality measures reported through a GPRO registry, the GPRO Web-Interface, or administrative claims to calculate the value modifier. For those who only reported one measure, CMS will use the group's performance on the administrative claims measures since it would not have sufficient quality information to construct a quality composite under the quality-tiering approach.

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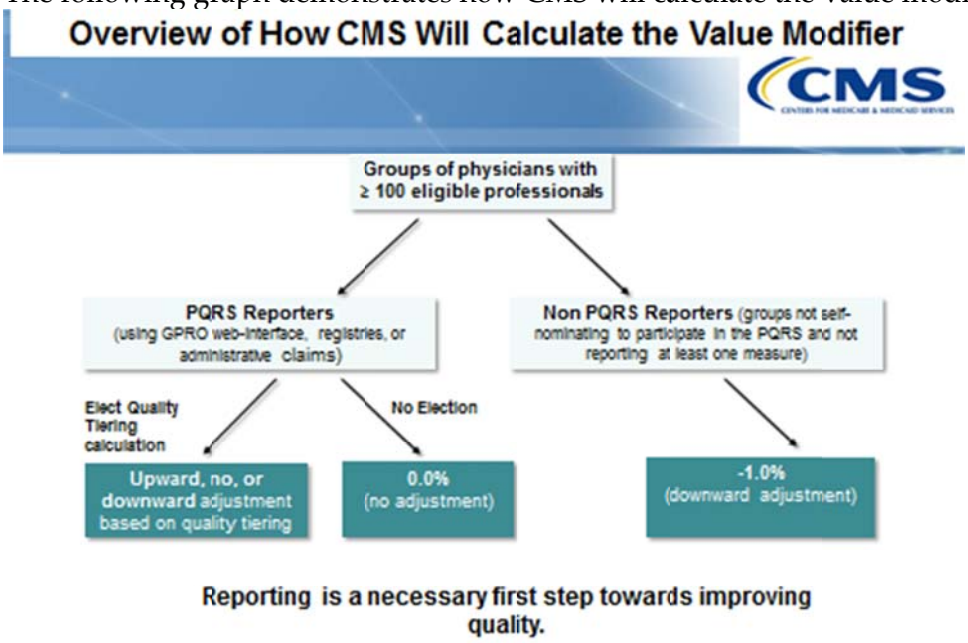
Groups in the second category would automatically receive 99.0% of the paid amounts for the items and services billed under the Medicare PFS.

The following graph demonstrates how CMS will calculate the value modifier.



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*from presentation "The 2013 Physician Fee Schedule Final Rule: Requirements for CMS Quality Reporting Programs" given by Dr. Patrick Conway on Dec. 3, 2012.

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Quality-Tiering Election Process

To ease administrative burden and to align the quality-tiering election process with the self-nomination processes under the PQRS, CMS finalized a web-based system for groups of physicians to request the quality-tiering methodology. Consistent with the PQRS, quality- tiering elections must be received by Oct. 15, 2013. Groups with 100 or more eligible professionals that do not self-nominate to participate in the PQRS GPRO or elect the administrative claims option for groups for CY2013, will be subject to the -1.0% payment modifier in CY2015.

Participants in the Medicare Shared Savings Program and Center for Medicare and Medicaid Innovation initiatives

CMS finalized its proposal to not apply the VBM for 2015 and 2016 to groups of physicians that are participating in the Medicare Shared Savings Program, the testing of the Pioneer ACO model, or other similar Innovation Center or CMS initiatives (such as the Comprehensive Primary Care initiative). These programs are still at their early stages and CMS does not wish to unintentionally disturb those who are already making substantial investments in providing higher quality, more efficient care.

Value Modifier Performance Period

CMS previously finalized CY2013 as the initial performance period for the VBM that will be applied in 2015. In this rule, the agency finalizes its proposal to use CY2014 as the performance period for the modifier in 2016. CMS received a number of comments expressing concern that using 2013 as the initial performance period for

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the 2015 value modifier was premature and provided insufficient time (3 months between publication of the final rule and the proposed GPRO self-nomination deadline) to educate professionals about the program, and to conduct additional testing and analysis to further refine the methodology and ensure that the modifier is fair and reliable. CMS feels it has taken steps to phase-in the VBM in a very gradual and cautious manner, as further evidenced by its decision to apply the modifier to groups of 100 or more professionals, to allow such groups to voluntarily select whether the quality-tiering approach would apply to the calculation of the VBM, and to extend to October 15 the period during which large groups can indicate their preferred PQRS reporting mechanism and whether they want to be held accountable under the quality-tiering approach. Although CMS agrees with suggestions to analyze different ways to structure and implement the VBM, it needs data on quality to do so and can only get that data by initiating the program.

PQRS Quality Reporting Methods and Quality Measures for Groups

Although CMS proposed to include four methods for groups of physicians to participate in the PQRS GPRO (Web-Interface, claims, registries, and EHRs), it finalized for PQRS and the value modifier only two for CY2013: the Web-Interface and registries methods. CMS recognizes concerns about the comparability of performance rates on measures reported through different reporting mechanisms and intends to examine this issue more fully in the future.

Quality Measure Alignment with the PQRS

The majority of commenters appreciated CMS' proposed flexibility of choice in reporting individual measures for the VBM. In fact, the clinical community cited that allowing physician groups to report on the entire spectrum of PQRS measures "recognizes the diversity of services provided among physicians and physician groups and allows for more appropriate assessments of quality." Therefore, CMS finalized all of the individual measures under the PQRS for 2013 and beyond for the VBM. CMS plans on expanding the specialty measures available in the PQRS in order to more accurately measure the performance on quality of care furnished by specialists. CMS believes that expanded group reporting options address concerns about the current set of PQRS measures not capturing all of the clinical care provided by specialists and sub-specialists. For example, the expansion of the GPRO to registries in 2013 and to EHRs in 2014 means that sub-specialists may participate in the PQRS as members of a group practice since the group would be able to report data on measures of broad applicability.

Cost Measures

In the CY 2012 PFS final rule, CMS finalized use of total per capita cost measures and per capita cost measures for beneficiaries with four specific chronic conditions (i.e., chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes) for the VBM. Total per capita costs include payments under both Part A and Part B, but not Medicare payments under Part D for drug expenses. In the 2013 final rule, CMS confirms its belief that these measures are useful and encourage shared accountability for beneficiary care. While CMS agrees with specialty society concerns that the cost measures are inappropriate for some specialties and would do little to change behavior since the majority of specialists do not treat one of the four chronic conditions, the agency only suggested that it would continue to look for ways to refine the current measures and potentially add other chronic conditions. CMS did not directly address specialty society objections to basing physician cost measures on total amount billed per patient, which assumes specialist responsibility for care and treatment decisions of the patient for which they have little control and for which they have limited ability to modify their practice to reduce costs.

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Proposed Payment Standardization Methodology for Cost Measures

CMS finalized its proposal to apply the CMS payment standardization methodology, which removes local or regional price differences that may cause cost variation a physician cannot influence through practicing efficient care, to the cost measures used for the VBM.

Risk Adjustment Methodology for Cost Measures

CMS finalized its decision to use the Hierarchical Condition Categories (HCC) model for risk adjusting total per capita costs and the total per capita costs for beneficiaries with four chronic diseases used to calculate the value modifier. The HCC model assigns prior year ICD-9-CM diagnosis codes to 70 high-cost clinical conditions (each with similar disease characteristics and costs) to capture medical condition risk. HCC risk scores also incorporate patient age, gender, reason for Medicare eligibility (age or disability), and Medicaid eligibility status, which is in part a proxy for socioeconomic status and reflects the greater resources typically used by beneficiaries eligible for both Medicare and Medicaid. The model also includes the beneficiary's end stage renal disease (ESRD) status. CMS updates the model regularly to reflect changes in treatment patterns and costs. CMS also is exploring how to incorporate additional aspects of coding completeness and quality into the model. This is the same model that CMS has used for the group and individual 2010 Physician Feedback reports. More information about the HCC model is available here.

Attribution of Quality and Cost Measures

CMS finalized the plurality of primary care attribution approach used for the Medicare Shared Savings Program to assign a beneficiary to an ACO. CMS believes aligning with the Shared Savings Program will create consistency across its various quality programs (even the PQRS GPRO Web Interface uses the similar plurality of care method). This is especially relevant given CMS' decision to apply the VBM to groups of 100 or more eligible professionals. Since the cost measures for the modifier will focus on total per capita costs, CMS also believes that it is reasonable to attribute beneficiaries to those groups of physicians that are most responsible for the delivery of primary care services and have the ability to furnish it in a cost-effective manner. Other reasons cited by the public that influenced CMS' decision to support this approach include the fact that patients that see a specialist for management of chronic conditions and receive a plurality of primary care services from the specialist would be appropriately attributed under this method.

Composite Scores for the Value-Based Payment Modifier

CMS finalized its proposal to construct quality composite scores by classifying each group's quality measures into one of the six National Quality Strategy domains, to weight each measure equally within each domain, and to weight the domains equally to form the quality composite. Likewise, CMS finalized its proposals to construct a cost composite by classifying each group's per capita cost measures into two domains – all patients and all patients with four specific chronic conditions, to weight each measure equally within each domain, and to weight the domains equally to form the cost composite.

CMS believes that forming each group of physicians' quality and cost composites by equally weighting quality measures in equally weighted domains makes the most sense when groups of physicians have flexibility to choose which measures they will report. CMS also feels this method is transparent and easily understood by physicians. CMS also noted that in cases where a group does not report measures in one or two of the domains, the remaining domains would be weighted equally and if the group only reports measures in a single domain, the domain would be weighted 100 percent. As with others, CMS will continue to monitor and examine this policy.

VBM Scoring Methods

In accordance with commenter support, CMS finalized its proposal to establish standardized scores for the VBM performance measures. CMS feels this approach will allow it to distinguish clearly between high and low performance and allow it to create composites of quality of care for groups of physicians that report different quality measures. CMS will consider the effects of this methodology over the next several years and may consider changes through future rulemaking.

Benchmarks and Peer Groups for Quality Measures

CMS finalized its proposal to use national benchmarks. CMS does not believe regional benchmarks are appropriate since it is already standardizing Medicare payments to eliminate regional payment differences. CMS will unify the calculation of the benchmark by weighting the performance rate of each physician and group of physicians submitting data (through any PQRS reporting method) on the quality measure by the number of beneficiaries used to calculate the performance rate.

To encourage transparency and credibility and to help physicians understand why their payments are being adjusted, CMS modified its proposal so that it will use the year prior to the performance year as the year for calculating the benchmark. This will give groups of physicians' information on national benchmarks prior to the end of the performance year. These benchmarks would be available publicly to inform a group of physicians' choice of PQRS reporting method for the applicable performance year.

Because CMS is allowing flexibility on the quality measures that groups of physicians can report, it believes that the most appropriate peer group consists of other physicians and physician groups reporting the same measure regardless of specialty. Under this approach, CMS expects physicians and physician groups will report data on the quality measures that best reflect the care they furnish.

Payment Adjustment Amount

PPACA specifies that the VBM must be implemented in a budget neutral manner, but does not specify the amount of physician payment that should be subject to the adjustment. CMS finalized its proposal to establish a -1 percent payment adjustment for groups of 100 or more professionals that fall into category two, as discussed above (neither self-nominate for the PQRS as a group and report at least one measure nor elect the PQRS administrative claims option for 2013). CMS also finalized its proposal to limit the downside payment adjustment for groups of physicians that elect the quality-tiering option at -1.0 percent.

In making this decision, CMS took into account the other adjustments affecting physicians' Medicare payment in 2015 (PQRS: -1.5% in 2015 based on 2013 reporting and -2.0% in 2016 based on 2014 data; EHR Incentive Program: -1.0% in 2015, or -2.0% if subject to the eRx Incentive Program adjustment in 2014, -2.0% in 2016, and -3.0% in 2017).

In response to concerns, CMS noted that budget neutrality prevents it from identifying the upward payment amount until all downward adjustments have been determined. However, CMS is open to comments on how it might provide an upward payment amount for future rulemaking. CMS also clarified that the total amount of upward payment adjustments is a fixed amount that is equal to the amount made available through downward payment adjustments.

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VBM Scoring Methodology

CMS finalized its proposal to use the quality-tiering model to determine the VBM modifier. This model compares the quality of care composite with the cost composite, classifying both composite scores into high, average, and low categories based on whether they are statistically above, not different from, or below the mean quality and cost composite score. CMS will establish the upward payment adjustment factor ("x") after the performance period has ended based on the aggregate amount of downward payment adjustments. The scoring methodology also will provide a greater upward payment adjustment (+1.0x) for groups of physicians that care for high-risk patients (as evidenced by the average HCC risk score of the attributed beneficiary population). CMS will not apply this additional upward payment adjustment for groups of physicians that select the PQRS administrative claims-based reporting option.

CMS believes this a reasonable way to phase in the VBM, to fine tune its methodology for identifying high and low performers over time, and to initially focus on outliers rather than trying to adjust the payment of every group of physicians. MedPAC also expressed support for applying the VBM bonus or penalty only when a physician group's performance is significantly different from the national mean, as well as an "outlier" approach to identify physicians or groups with extraordinarily higher or lower costs than average. The table below illustrates this approach:

TABLE 126: Value-Based Payment Modifier Amounts for the Quality-Tiering Approach

Quality/cost	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Average quality	+1.0x*	+0.0%	-0.5%
Low quality	+0.0%	-0.5%	-1.0%

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

Proposed Informal Review and Inquiry Process

Despite a statutory preclusion of administrative and judicial review, CMS believes it is useful for groups of physicians to understand how their payment under the PFS could be changed by the VBM. CMS also believes that an informal mechanism is needed for groups of physicians to review and to identify any possible errors prior to application of the modifier. Therefore, it intends to disseminate Physician Feedback reports containing calendar year 2013 data in the fall of 2014 to groups of physicians subject to these policies (see next section). CMS noted it will make feedback reports available during the fall of 2014 for all groups of physicians affected by the VBM in 2015 and, as discussed below, will make enhancements suggested by commenters so that the reports provide more meaningful and actionable data, as well as make a help desk available to address questions related to the reports.

Physician Feedback Program

CMS is required under statute to provide confidential reports to physicians that measure the resources involved in furnishing care to Medicare FFS beneficiaries, as well as quality. In the fall of 2012, it plans to disseminate Physician Feedback reports (also termed the "Quality and Resource Use Reports" or QRURs) to physicians in nine states (i.e., CA, IA, IL, KS, MI, MN, MO, NE, and WI) based on 2011 data. These reports will contain the PQRS measures that physicians in these states submitted via any of the PQRS reporting methods, as well as information on 28 administrative claims measures included in the 2010 reports. CMS also will

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produce and disseminate Physician Feedback reports to the groups of physicians that reported measures through the PQRS GPRO Web Interface in 2011.

CMS plans to increase outreach to encourage physicians to view their reports, to begin to understand the methodologies adopted in this final rule for the VBM and that are included in the 2011 reports, and to provide suggestions on how to make the reports more meaningful and actionable in the future.

- In the fall of 2013, CMS will produce and disseminate Physician Feedback reports at the TIN level to all groups of physicians with 25 or more eligible professionals. CMS also is required, under statute, to use the episode-based cost in the Physician Feedback reports beginning in 2013 and based on 2012 data. CMS plans to include episode-based cost measures for several episode types in future Physician Feedback reports.
- In the fall of 2014, CMS will disseminate Physician Feedback reports to all groups of physicians (at the TIN level) with 25 or more eligible professionals, even though groups of physicians with 25 to 99 eligible professionals will not be subject to the modifier in 2015. These reports would be the basis of the VBM in 2015 and would contain, among other things, quality and cost measure performance and benchmarks used to score the composites. CMS is examining whether it can provide reports to groups of physicians with fewer than 25 eligible professionals and individual level reports, as well.

CMS received many suggestions on ways to improve the content, format, and distribution of the Physician Feedback reports. These included working with national and state medical specialty societies to ensure that physicians understand the reports, to make the content more actionable for quality improvement, and to increase physician awareness of the programs. Others suggested that CMS develop a mechanism for interpretation of feedback reports and meaningful dialogue between physicians, specialty society staff, and CMS. The agency appreciated these suggestions and is working with the AMA, state medical societies, specialty societies (including the AGA), and other stakeholders to address these issues in future feedback reports.

Physician Compare Website

PPACA required CMS to develop a physician compare website with information on physicians enrolled in the Medicare program. Since the initial launch in 2010, CMS continues to build and improve the website. The Physician Compare Website now includes information on physicians enrolled in the Medicare program and on those who satisfactorily participated in the PQRS and the e-Prescribing (eRx) Incentive Program based on the most recent data available for these two quality initiatives. CMS finalized the following proposals regarding the physician compare website.

- CMS will implement a plan for making physician *performance* data on quality and patient experience publicly available.
- CMS will post performance information collected through the 2012 PQRS GPRO Web Interface on Physician Compare in 2013 or early 2014. For its next phase, CMS will post, no sooner than 2014, 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.
- For 2013, CMS will publicly report on measures that meet a minimum sample size (20 patients, revised from the original proposal of 25) and are suitable for public reporting (i.e., statistically valid and reliable).

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- CMS will report patient experience data, collected no earlier than 2013, on Physician Compare in 2014, for groups of 100 or more eligible professionals reporting via the GPRO web interface, including ACOs participating in the Shared Savings Program. CMS will administer the patient experience survey for 2013 and 2014, which should minimize the burden for these targeted groups.
- CMS will post the names of professionals who earned an incentive in the PQRS Maintenance of Certification Incentive Program (MOC) as data are available, and targeted for 2014.
- CMS also proposed to publicly report, no earlier than 2016, performance rates on quality measures included in the 2015 PQRS and VBM for individual professionals. In response to support for this proposal, CMS decided to move up the start date, aiming to post individual-level measure data in 2015 using 2014 data. Further discussion of this topic, including the measures to be included, will be addressed in future rulemaking.
- In the proposed rule, CMS also considered allowing measures that have been developed and collected by approved and vetted specialty societies to be reported on Physician Compare. Many commenters supported this proposal, noting it was a good way to identify measures that are most appropriate for certain specialties and to reduce the reporting burden on those specialties since these measures are already being collected. CMS agreed and intends to work with specialty societies to identify the most appropriate data sources and mechanisms for inclusion on Physician Compare.

A majority of commenters expressed concern about the accuracy of data currently on Physician Compare, as well as frustration over how difficult it is to get information updated or corrected. In 2012, CMS intends to enhance the accuracy of "administrative" information displayed on the eligible professional's profile page (i.e. from the Provider Enrollment, Chain, and Ownership System (PECOS)), and to add additional information, including whether a professional is accepting new Medicare patients, board certification information, and improvements to hospital affiliation data. CMS emphasized the importance of professionals ensuring that data in PECOS is up-to-date since it is the primary data source for Physician Compare. CMS is evaluating other options for professionals to update their information and is looking at other available data sources to further improve accuracy of data presented on Physician Compare. CMS reminded the public that it will provide a 30-day preview period for professionals to view their data prior to it being posted on the site, which aligns with other public reporting programs such as Hospital Compare, and will closely evaluate all measures to ensure they are presented in a way that is valuable to consumers. CMS also announced that a full website redesign is slated for early 2013 to further prepare Physician Compare for the introduction of quality data and ACO information.

CMS agreed with requests for a disclaimer that explains why measures may not apply to certain groups and that the absence of data on a particular measure does not imply poor performance or poor quality. It is currently evaluating disclaimer language for use on Physician Compare and will take this feedback into consideration.