2013 Medicare Physician Fee Schedule
Proposed Rule Summary

On July 6, 2012, CMS issued the 2013 Medicare physician fee schedule (PFS) proposed rule, which was published in the *Federal Register* on July 30. Comments on the rule will be accepted until Sept. 4 and a final rule is expected by Nov. 1, 2012.

The proposed rule revises payment policies under the Medicare PFS and proposes changes to a number of physician incentive programs, including the Physician Quality Reporting System (PQRS), the electronic prescribing (eRx) program, and the PQRS-Medicare electronic health records (EHR) incentive pilot. 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*," which CMS proposes for claims and registry reporting.

Payment Provisions

CMS projects a significant reduction of 27 percent to payment rates for physicians' services in 2013 under the sustainable growth rate (SGR) methodology due to the expiration of the adjustment made for calendar year (CY) 2012 in the statute. Review a detailed payment analysis for GI codes.

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. CMS has stated in the past that they will continue to work with Congress to fix this untenable situation so doctors and beneficiaries no longer have to worry about the stability and adequacy of their payments from Medicare under the PFS.

AGA, along with the rest of the medical community, continues to work with Congressional leaders, urging them to permanently address the broken Medicare physician payment system, and replace it with a more stable and equitable payment mechanism that reflects the costs of caring for Medicare beneficiaries and ensures access to high quality care.

Resource-Based Practice Expense Relative Value Units

CMS proposes a few modifications to the development of practice expense relative value units (RVUs). With respect to rate-setting, CMS proposes calculating the specialty mix for low volume services (fewer than 100 billed services in the previous year) using the same methodology it has used for non- low volume services. In the past, CMS used survey data from the dominant specialty;

however, because these services have such low utilization, the dominant specialty tends to change from year to year.

In an effort to accurately capture equipment costs per minute, CMS asked for reliable data on current prevailing loan rates for small businesses in the 2012 proposed rule. In the 2013 proposed rule, CMS proposes adopting the AMA/Specialty Society Relative Value Scale Update Committee's (RUC) recommendation regarding equipment cost per minute. CMS would use a "sliding scale" approach based on the current Small Business Administration maximum interest rates for different categories of loan size (price of the equipment) and maturity (useful life of the equipment).

Potentially Misvalued Codes Under the Physician Fee Schedule

Bundling & Episodes of Care

CMS outlines new requirements stemming from the Middle Class Tax Cut and Job Creation Act of 2012. Specifically, the statute requires that the secretary of HHS conduct a study examining options for bundled or episode-based payments 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. The study will include an examination of related private payor payment initiatives, recommendations on suitable alternative payment options for services paid under the PFS and on associated implementation requirements. The secretary is directed to consult with medical professional societies and other relevant stakeholders while conducting the study and is required to submit a report on the study to Congress by Jan. 1, 2013.

According to CMS, bundling is one method for structuring payment that can improve payment accuracy and efficiency. CMS notes that its ongoing work identifying, reviewing and validating the relative value units (RVUs) of potentially misvalued services in the PFS will support the development of this report, as well as its newly proposed efforts to improve the value of the global surgical package, discussed below. CMS will continue to examine options for bundled or episode-based payments and will include its recommendations and implementation options in the report to Congress.

Global Surgical Package

CMS proposes improving the value of the global surgical package for certain services. Interest in this initiative stems from CMS' existing efforts and several reports from the Office of the Inspector General that noted the global surgical package for certain services may be misvalued because the number and level of post-operative evaluation and management (E/M) services were greater than what is provided. CMS seeks comments on methods of obtaining accurate and current data on E/M services furnished as part of a global surgical package.

Review of Codes with Annual Charges of $10 Million or More

CMS also proposes reviewing Harvard-valued current procedural terminology (CPT) codes with annual allowed charges of $10 million or more as a part of the potentially misvalued codes initiative. According to CMS, these codes have not been reviewed since they were originally valued in the early 1990s. CMS states that codes meeting these criteria have relatively low Medicare utilization, but they account for significant Medicare spending annually. Using CY 2011 claims data, CMS identified a list

of codes for review. Among the codes is 43264: *Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts.*

Expanding the Multiple Procedure Payment Reduction Policy

For services furnished on or after Jan. 1, 2013, CMS will apply the multiple procedure payment reduction (MPPR) to both the professional component and the technical component of advanced imaging procedures to multiple physicians in the same group practice (same group national provider identifier). Under this policy, the MPPR will apply when one or more physicians in the same group practice furnish services to the same patient, in the same session, on the same day.

A policy was finalized last year to do this; however, due to operational limitations, CMS was not able to apply the MPPR to multiple physicians in the same practice. CMS has since resolved the operational problem and will now apply the MPPR policy for imaging services furnished in the same session by physicians in the same group practice.

Geographic Practice Cost Indices

CMS proposes no changes for 2013, but anticipates recommendations in future rulemaking. The agency discussed the expiration of the work geographic practice cost indices (GPCI) floor and discussed the Institute of Medicine (IOM) recommendations on geographic adjustments.

Expiration of Floor

CMS notes the expiration of the statutory 1.0 work GPCI floor that was extended throughout the remainder of CY 2012. Since it has not been extended beyond 2012, this proposed rule does not reflect the 1.0 work GPCI floor for CY 2013.

IOM Recommendations

IOM released the first of two anticipated reports on geographic adjustments, which contained a recommendation to alter the current locality structure. Rather than using the current uniform fee schedule areas in adjusting for relative cost differences as compared to the national average, IOM recommends a three-tiered system for defining fee schedule areas. In the first tier, IOM proposes applying county-based fee schedule areas to calculate the employee wage component of the practice expense GPCI. The IOM's second tier would use a metropolitan statistical area-based approach for the work GPCI, the office rent index, the purchased services index and the malpractice GPCI. In the third payment area tier, the IOM proposes creating a national payment area for the "equipment, supplies and other" index.

CMS' contractor conducted an analysis of IOM's proposal and noted there would be significant redistributive impacts if the agency was to implement a policy that would reconfigure the PFS localities based on the IOM's three-tiered recommendation. CMS notes that before moving forward with the IOM's recommendation, or any other potential locality revision, the agency needs to assess the impact of any change for all Medicare stakeholders.

Medicare Telehealth Services

CMS proposes adding intensive behavioral therapy for obesity, reported by Healthcare Common Procedure Coding System (HCPCS) code G0447 (face-to-face behavioral counseling for obesity, 15

minutes) to the list of telehealth services for CY 2013. The code is proposed on a category one basis, meaning CMS has determined this service is similar to other services currently on the list of telehealth services.

Extension of Payment for Technical Component of Certain Physician Pathology Services

Last year, CMS finalized a policy that an independent lab may not bill the Medicare contractor for the technical component (TC) of physician pathology services furnished after Dec. 31, 2011, to a hospital inpatient or outpatient. Subsequent to the rule, Congress acted to continue payments through June 2012. In 2013 proposed rule, CMS proposes conforming changes such that CMS will continue payment under the PFS to independent laboratories furnishing the technical component 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 technical component 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 considering 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

CMS proposes refining PFS payment for post-discharge care management services. Specifically, CMS proposes increasing payments for primary care specialties through the use of a new care coordination code (HCPCS code GXXX1). This code would be reported by primary care physicians and some specialists for managing a beneficiary's care when the beneficiary is discharged from an inpatient hospital, a skilled nursing facility, an outpatient hospital observation, partial hospitalization services or a community mental health center. Since changes to the physician fee schedule are conducted in a budget-neutral manner, this would mean that payments to select other specialties would decrease. In order to pay for these increased payments for primary care, CMS proposes reductions in total payments projected for cardiologists, ophthalmologists and radiation oncology treatments.

The new HCPCS G-code would describe all non-face-to-face services related to the transitional care management furnished by the community physician or qualified nonphysician practitioner within 30 calendar days following the date of discharge from the settings mentioned above. CMS uses the term "community physician" to refer to the community-based physician managing and coordinating a beneficiary's care in the post-discharge period.

Eligible Providers

CMS assumes that only one provider will bill the coordination code and will make one payment per patient discharge. Providers who are NOT eligible to bill include those receiving payment for the patient under a 10- or 90-day global payment, providers who received payment for discharge

services, and providers who are receiving payment for home health or hospice care plan oversight services.

CMS seeks comment as to whether the non-face-to-face care management services provided by clinical staff member(s) or office-based case manager(s) under the supervision of the community physician or qualified nonphysician practitioner is appropriate.

Payment
With regard to payment, CMS proposes the following work RVUs, physician time and malpractice RVU crosswalk.

Proposed HCPCS Code	Descriptor	Work RVU	Phys. Times	Clinical Labor Crosswalk	MP RVU Crosswalk
GXXX1	Post-discharge transitional care management	1.28	8 minutes pre-evaluation, 20 minutes intra-service and 10 minutes immediate post-service.	99214	99214

Primary Care Services Furnished in Advanced Primary Care Practices
CMS discusses the possibility of establishing enhanced payments for care coordination activities inside of an advanced primary care practice (i.e., medical home) and seeks comment on how Medicare would recognize and pay for those services. CMS discusses the Innovation Center's comprehensive primary care (CPC) initiative, which provides a set of five "comprehensive primary care functions" that form the service delivery model being tested and the required framework for practice transformation under the CPC initiative. CMS believes these five functions provide an appropriate starting point for discussing the incorporation of the comprehensive primary care services delivered in advanced primary care practices (i.e., practices implementing a medical home model) into the PFS. The functions include risk-stratified care management, access and continuity, planned care for chronic conditions and preventive care, patient and caregiver engagement, and coordination of care across the medical neighborhood.

CMS is seeking comment on how practices would be deemed an "advanced primary care practice," specifically whether by the existing nationally available accreditation programs (e.g., patient-centered medical home status) or new criteria developed by CMS and based upon the five functions in the CPC initiative. CMS is also seeking comment on attribution of a beneficiary to an advanced primary care practice.

Payment for Molecular Pathology Services

The molecular pathology community continues to debate whether Medicare should pay for molecular pathology tests under the clinical laboratory fee schedule (CLFS) or the PFS. CMS proposes to price all of the 101 new molecular pathology codes through a single fee schedule, either the CLFS or the PFS. The agency is meeting with stakeholders to assess variations in the laboratory methodologies and for establishing payment rates under the PFS and the CLFS. CMS acknowledges that if the agency decided to finalize payment for molecular pathology services under the PFS, they would not propose

national payment rates at this time. Instead, the agency would allow Medicare contractors to price the codes since the price of tests can vary locally.

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. For CY 2013, CMS proposes a work RVU of 0.45, physician time of 15 minutes and a malpractice RVU that is crosswalked to CPT 97803.

Ordering of Portable X-Ray Services

CMS proposes to revise its current regulations, which limit ordering of portable x-ray services to only an MD or DO, to allow other physicians and nonphysician practitioners acting within the scope of their Medicare statutory benefit and state law to order portable x-ray services. This proposed change would allow an MD or DO, as well as a nurse practitioner, clinical nurse specialist or physician assistant, to order portable x-ray services within their state scope of practice and the scope of their Medicare benefit. 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 proposes to maintain the threshold for the widely available market price (WAMP) and the average manufacturer price (AMP) at 5 percent. CMS discusses AMP price substitution for average sales price (ASP) and notes the agency did not apply the price substitution policy in April 2012 given the recent drug shortage issues. CMS proposes adding regulatory language that would prevent the AMP price substitution policy from taking effect if the drug and dosage 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 are being finalized for the next quarter.

Quality Provisions

CMS proposes changes to the quality reporting initiatives associated with Medicare physician fee schedule payments. A summary of the proposals are included below.

Physician Quality Reporting System

Following are brief examples of proposed changes to the Physician Quality Reporting System (PQRS):

- Modification to the definition of group practice from "25 or more" to "2 or more" eligible professionals, allowing groups of smaller sizes to participate in the group practice reporting option (GPRO).
- Group practices must submit self-nominations to participate in the GPRO via the Web. CMS will no longer accept written letters accompanied by an electronic file, as it did in the past.

- Beginning in 2013, group practices can report data on quality measures using the claims, registry and EHR-based reporting mechanisms for the PQRS incentive and payment adjustment, or use the new proposed administrative claims reporting option (described below).
- For 2013 and beyond, registries would have to be qualified to report PQRS quality measures for each reporting period. Registries would have to undergo a self-nomination process and qualification process regardless of whether the registry was qualified the previous program year.
- CMS proposes a new process to audit qualified registries. If CMS finds during an audit that a qualified registry has submitted grossly inaccurate data, the agency will disqualify the registry from reporting the subsequent year.
- CMS proposes to no longer require qualification of EHR products in order to be used for reporting under the PQRS. CMS would still allow EHR vendors to submit test files to the PQRS and continue to provide support calls, however the agency would no longer require vendors to undergo this testing or qualification process.
- A new administrative claims reporting option for the 2015 and 2016 PQRS payment adjustments only. CMS would analyze a group practice's Medicare claims to determine whether they have performed the clinical quality actions indicated in the proposed PQRS quality measures that apply to this reporting mechanism. Those electing to use this mechanism would be required to report a list of measures for 100 percent of the cases in which the measures apply.
- CMS proposes adding a six-month reporting period (July 1 — Dec. 31, 2013) for the 2015 payment adjustment for the reporting of measures groups via registry. For 2016 payment adjustments, to coincide with the reporting periods for the 2014 incentive, CMS proposes a 12- month (Jan. 1 — Dec. 31, 2014) reporting period and, for individuals reporting measures groups via registry only, a six-month (July 1 — Dec. 31, 2014) reporting period.
- CMS intends to move toward a 12-month reporting period for future years. For 2017 and beyond, CMS proposes using a 12-month reporting period that falls two years prior to the applicability of the respective payment adjustment (e.g., Jan. 1 — Dec. 31, 2015, for the 2017 payment adjustment).
- CMS will align the PQRS with the reporting requirements a professional must satisfy for the clinical quality measure (CQM) component of meaningful use (MU) under the EHR incentive program.
- CMS is considering modifying the beneficiary assignment method used in the PQRS GPRO so that it is consistent with the shared savings program methodology. CMS is considering making this change to the assignment method beginning with the 2013 PQRS GPRO Web interface so that the rules used to assign beneficiaries to group practices participating in PQRS and ACOs participating in the Medicare Shared Savings Program are consistent.
- During the 12- month reporting periods for the 2015 and 2016 payment adjustments, eligible professionals and group practices may report only one measure or measures group using the claims, registry or EHR-based reporting mechanisms.
- CMS proposes extending the PQRS-Medicare EHR incentive pilot for the 2013 payment year.

Review the criteria for reporting requirements for the PQRS program.

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 has also included the following proposals for PQRS quality measures for 2013 and beyond:

- For 2013, a total of 264 measures, 250 of which were previously included in the 2012 PQRS. A new gastroenterology PQRS measure, *"Endoscopy and Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients,"* is proposed 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.
- Adding a measure to the PQRS for 2013 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.*"
- Retire PQRS measure "*Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR).*" CMS anticipates that most eligible professionals reporting via EHR will also participate in the EHR incentive program, and therefore believes it is redundant to have an eligible professional report on whether or not s/he has adopted an EHR.
- For 2014, introduction of 34 new measures and retiring eight measures that were previously established for reporting under the 2012 PQRS. Included among those to retire is PQRS measure 173 *Preventive Care and Screening: Unhealthy Alcohol Use – Screening* since it was recommended for removal from reporting by the measure applications partnership.
- A new *CG-CAHPS Clinician/Group Survey* measure available for reporting through the GPRO Web interface in 2013 and beyond. Since this survey measure requires a different form of data collection and analysis than the other proposed measures, CMS intends to administer the survey on behalf of the group practices participating in the 2013 PQRS GPRO.
- Retaining the current IBD and hepatitis C measures groups. In addition, for 2013, CMS is proposing a new oncology group with measures related to colon cancer.

Medicare Shared Savings Program and PQRS

CMS proposes to amend the shared savings program to incorporate reporting requirements for the PQRS payment adjustment. The reporting period for the payment adjustment would fall two years prior to when the payment adjustment would be assessed (e.g., under the shared savings program, the reporting period for the 2015 payment adjustment would be from Jan. 1 through Dec. 31, 2013).

Electronic Prescribing (eRx) Incentive Program

CMS finalized requirements for the 2013 and 2014 eRx incentive program in a previous rule, however the agency is proposing revisions to the group practice reporting option, two additional hardship exemptions and an informal review process.

eRx GPRO

For the eRx group practice reporting option (GPRO), CMS proposes changing the minimum practice size from 25 to two, and will add this to the criterion for being a successful electronic prescriber for the program. Since CMS proposes to change the definition, the agency also proposes to lower the reporting thresholds for these group practices participating in the eRx GPRO:

- For the 2013 incentive: groups must report the e-prescribing measure's numerator code during a denominator-eligible encounter for at least 225 times during the 12-month 2013 incentive reporting period (Jan. 1 — December 31, 2013).
- For the 2014 adjustment: report the electronic prescribing measure's numerator code at least 225 times for the six-month 2014 payment adjustment reporting period (Jan. —June 30, 2013).

Proposed Significant Hardship Exemptions

CMS acknowledges that stakeholders participating in the EHR program, which requires a certain level of electronic prescribing, are also beholden to the eRx payment adjustments. For this reason, CMS proposes including additional hardship exemptions for the 2013 and 2014 eRx payment adjustment periods, which would essentially exempt these providers from the eRx penalties:

- Eligible professionals or group practices that achieve meaningful use during certain eRx payment adjustment reporting periods.
- Eligible professionals or group practices that demonstrate intent to participate in the EHR incentive program and adoption of certified EHR technology. CMS recognizes that even once certified EHR technology is adopted, significant changes and workflow redesign are required to facilitate adoption and information exchange, and that it may be difficult for an individual or group practice to begin e-prescribing on day one. Therefore, under this exemption, professionals or group practices must register to participate in the Medicare or Medicaid EHR incentive programs and adopt certified EHR technology by a date specified by CMS.

Those requesting one of these hardship exemptions must meet the requirements by Oct. 15, 2012, to avoid the 2013 eRx payment adjustment.

Informal Review Process

CMS proposes establishing an informal review process for the eRx incentive program. For an informal review regarding the 2013 incentive, CMS proposes that an eligible professional or group practice must request an informal review within 90 days of the release of his or her feedback report, irrespective of when an eligible professional or group practice actually accesses the feedback report. For the 2014 payment adjustment, an eligible professional or group practice must request a review by Jan. 31, 2013. CMS would provide the eligible professional or group practice with a written response to the request for an informal review within 90 days of receiving the request. Decisions based on the informal review would be final, and there would be no further review or appeal.

Physician Feedback Program

The secretary is required to provide confidential physician feedback reports to physicians who measure the quality and resources involved in furnishing care to Medicare fee-for-service beneficiaries. These reports provide the foundation for CMS's proposals for the value-based payment modifier (additional information included below). CMS acknowledges that results from the most recent group practice reports show little correlation between quality of care furnished and cost for the 35 participating group practices to which it provided reports. CMS notes the overall results from the individual physician feedback reports based on 2010 data show that clinical care is highly fragmented and there is substantial room for improvement in the quality of care furnished to Medicare fee-for-service beneficiaries.

CMS also acknowledges the challenges physicians have faced in accessing these reports and will increase outreach efforts to encourage physicians to view their reports and provide suggestions on how the agency can make these reports more meaningful and actionable in the future.

- In the fall of 2012, CMS plans to disseminate physician feedback reports to all physicians in nine states (California, Iowa, Illinois, Kansas, Michigan, Minnesota, Missouri, Nebraska and Wisconsin) based on 2011 data.
- In the fall of 2013, CMS will produce and disseminate physician feedback reports at the tax identification number (TIN) level to all groups of physicians with 25 or more eligible professionals and to individual physicians who satisfactorily reported measures through PQRS in 2012 using any of the PQRS reporting mechanisms.
- In the fall of 2014, CMS plans to disseminate physician feedback reports to all groups of physicians (at the TIN level) with 25 or more eligible professionals and possibly provide reports to small group practices and individual physicians.

Value-Based Payment Modifier

PPACA requires the secretary to establish a budget-neutral payment modifier that provides for differential payment to a physician or a group of physicians under the PFS based on the quality of care furnished compared to cost. The payment modifier will be applied beginning Jan. 1, 2015, to specific physicians and groups of physicians who the secretary determines appropriate, and will apply to all physicians by 2017. The secretary is required to provide confidential physician feedback reports to physicians who measure the resources involved in and quality of furnishing care to Medicare beneficiaries.

CMS designed its value-based modifier proposals to: (1) provide groups of physicians with 25 or more eligible professionals an option that their value-based payment modifier be calculated using a quality-tiering approach; (2) focus the payment adjustment (both upward and downward) on those groups of physicians who are outliers, i.e., those statistically different than the mean; and (3) align the value-based payment modifier with the PQRS and utilize Medicare claims data in order to reduce administrative burden on groups of physicians. CMS believes these proposals are adaptable to smaller groups of physicians and physicians in solo practices who will be subject to the modifier starting in 2017. In the long run, CMS thinks the value-based payment modifier should rely on measuring physician value at four levels — the individual physician level, the group practice level, the facility level and the community level.CMS envisions a value-based payment modifier in the future that blends performance at each of these levels.

Proposed Application of the Value-Based Payment Modifier

Initial Application to Large Group Practices

CMS proposes to initially include all physician groups with 25 or more eligible professionals in the value-based payment modifier framework. For purposes of defining group size (i.e., those practices that would be affected by the modifier in the first payment year or 2015, based on 2013 data), CMS defines eligible professionals as (1) a physician; (2) a practitioner [i.e., a physician assistant, nurse practitioner, clinical nurse specialist, certified nurse anesthetist, registered dietitian or nutrition

professional]; (3) a physical or occupational therapist or a quality speech-language pathologist; or (4) a qualified audiologist. It also defines a group as "a single Tax Identification Number (TIN) with 25 or more eligible professionals, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN," which aligns with the definition used for the PQRS GPRO.

The value-based payment modifier would be applied to the Medicare paid amounts for the items and services billed under the PFS at the TIN level so that beneficiary cost-sharing or coinsurance would not be affected. It would apply to items and services billed by physicians under the TIN, not to other eligible professionals who also may bill under the TIN. In addition, CMS will not "track" or "carry" a physician's performance from one TIN to another TIN, so if a physician changes groups from TIN A in the performance period (2013) to TIN B in the payment adjustment period (2015), CMS would apply TIN B's value-based payment modifier to the physician's payments for items and services billed under TIN B during 2015.

CMS would allow physician groups to decide how the value-based payment modifier would be applied to their payments. The agency proposes to separate physician groups into two categories based on how they have chosen to participate in the PQRS.

Physician Groups: Category One

The first category includes those groups that have met the criteria for satisfactory reporting of data on PQRS quality measures for the 2013 and 2014 incentives or the criteria for satisfactory reporting using the administrative claims-based reporting mechanism. CMS proposes to initially set the value-based payment modifier at 0 percent for these groups of physicians.

Within this category, CMS proposes to calculate their value-based payment modifier using a quality-tiering approach. This option would allow these groups of physicians to earn an upward payment adjustment for high performance (high-quality tier and low-cost tier), and be at risk for a downward payment adjustment for poor performance (low-quality tier and high-cost tier). Due to the budget neutrality requirement, CMS cannot specify the exact amount of the upward payment adjustment for groups of physicians achieving high performance, but proposes a maximum downward payment adjustment for these groups of -1.0 percent for poor performance.

Physician Groups: Category Two

The second category includes those groups of physicians with 25 or more professionals that have <u>not</u> met the PQRS satisfactory reporting criteria, including those groups that have decided not to participate in any PQRS reporting mechanism. Because CMS would not have quality measure performance rates on which to assess the quality of care furnished by these groups of physicians, it proposes to set their value-based payment modifier at -1.0 percent. This 2015 adjustment would be in addition to the -1.5 percent payment adjustment for failing to meet the satisfactory reporting criteria under PQRS.

Medicare Shared Savings Program and the Value-Based Payment Modifier

CMS proposes not to offer groups of physicians participating in the Medicare Shared Savings Program or associated with the Pioneer ACO program and meet the PQRS satisfactory reporting

criteria the option for their value-based payment modifier to be calculated using the quality-tiering approach. CMS recognizes that these practices have made sizable investments to redesign care processes and are already committed to reporting on a broader set of quality measures than proposed for the value modifier.

Proposed Performance Period

CMS previously finalized CY 2013 as the initial performance period for the value-based payment modifier that will be applied in 2015. Likewise, it proposes that performance in CY 2014 be used to calculate the modifier that will be applied to payments in 2016.

Proposed Quality Measures

Alignment with PQRS Satisfactory Reporting Criteria

Group practices would be able to submit data on quality measures using one of the following proposed PQRS reporting mechanisms: GPRO using the Web-interface, claims, registries, EHRs or the new administrative claims-based option. CMS would include all individual measures in the PQRS GPRO Web-interface, claims, registries and EHR reporting mechanisms for 2013 and beyond for the value-based payment modifier.

CMS is concerned that some groups may attempt to submit data on PQRS quality measures using one of the GPRO reporting mechanisms (Web-interface, claims, registries or EHRs) and fail to meet the criteria for satisfactory reporting and thus be categorized as non-PQRS reporters (and be subject to the -1.0 percent downward adjustment). CMS therefore seeks comment on whether to assess performance on the measures included in the PQRS administrative claims-based reporting option as a default if a group of physicians attempts to participate in one of the PQRS GPRO reporting mechanisms and does not meet the PQRS criteria for satisfactory reporting.

Outcome Measures for Groups of Physicians

CMS feels it is appropriate to focus on potentially preventable hospital admissions since the 2010 physician feedback reports have shown that hospital inpatient, outpatient and emergency department costs account for more than 50 percent of total per capita costs. CMS proposes including four outcome measures in the value-based payment modifier for all groups of physicians to assess the rate of potentially preventable hospital admissions. CMS will seek National Quality Forum endorsement for the following measures:

- Composite of acute prevention quality indicators that combines the rates of potentially preventable hospital admission for dehydration, urinary tract infection and bacterial pneumonia.
- Composite of chronic prevention quality indicators that combines the rates of potentially preventable hospital admissions for diabetes, heart failure and chronic obstructive pulmonary disease.
- All cause readmission to include the rate of provider visits within 30 days of discharge from an acute care hospital (used in the Medicare Shared Savings Program).
- 30-day post discharge visit to include the rate of provider visits within 30 days of discharge from an acute care hospital (used in the physician group practice transition demonstration).

Proposed Cost of Care Measures

By statute, CMS is required to evaluate costs, to the extent practicable, based on a composite of appropriate measures of costs. In 2012, CMS finalized use of total per capita cost measures and per capita costs measures for beneficiaries with four specific chronic conditions (chronic obstructive pulmonary disease, heart failure, coronary artery disease and diabetes) for the value-based payment modifier. Total per capita costs include payments under both Part A and Part B, but not Medicare payments under Part D for drug expenses. CMS proposes to use at least a 60-day run out (e.g., claims paid through March 1 of the year following Dec. 31, the close of the performance period) to calculate the total per capita cost measures. CMS uses these cost measures in the physician feedback reports for individual physicians and physician groups and proposes to use them to calculate the cost composite for the value-based payment modifier.

Proposed Payment Standardization Methodology for Cost Measures

CMS is required to standardize Medicare payments to ensure fair comparisons across geographic areas. Payment standardization removes local or regional price differences that may cause cost variation a physician cannot influence through practicing efficient care. CMS has developed, with stakeholder input, a detailed Medicare payment standardization methodology that excludes geographic payment rate differences. The methodology eliminates adjustments made to national payment amounts that:

- Reflect practice expense and regional labor cost differences (measured by the GPCI and hospital wage index).
- Substitute a national amount when services are paid using a state fee schedule
- Eliminate supplemental payments to hospitals that treat a high share of poor and uninsured patients (i.e., Medicare disproportionate share hospital payments) or that receive indirect graduate medical education payments.
- Remove incremental payments for community hospitals and Medicare-dependent hospitals above their base payments.
- Eliminate certain rural add-on payments for inpatient psychiatric hospitals and inpatient rehabilitation facilities.

The CMS payment standardization methodology also eliminates the effect of incentive payments under the PFS for physicians who furnish services in rural areas and other underserved communities, such as professional shortage areas, such that they are not disadvantaged in the value-based payment modifier. Outlier payments are treated as they would be if payments were not standardized, but they are adjusted to reflect wage differences. CMS proposes to use this methodology for the value-based payment modifier.

Proposed Risk Adjustment Methodology for Cost Measures

CMS is required to adjust costs based on risk factors, health status and other factors. After standardizing per capita costs for geographic factors, CMS also risk adjusted the physician feedback reports based on the unique mix of patients attributed to the physician or group of physicians. Costs for beneficiaries with high risk factors (such as a history of chronic diseases, disability or increased age) are adjusted downward and costs for beneficiaries with low risk factors are adjusted upward. This risk adjustment methodology uses the CMS hierarchical condition categories model, which

incorporates beneficiary characteristics and prior year diagnoses to predict relative Medicare Part A and Part B payments. The model is updated every year to incorporate new diagnosis codes and is recalibrated regularly to reflect more recent diagnosis and expenditure data. CMS believes this approach provides a reasonable method to adjust per capita costs based on beneficiary characteristics.

Attribution of Quality and Cost Measures

In the 2010 physician feedback reports, CMS used two different attribution methodologies: one method for individual physicians ("degree of involvement method") and another method for groups of physicians ("plurality of care method"). For the plurality method, CMS attributed Medicare fee-for-service beneficiaries to the group practice that billed a larger share of office and other outpatient E/M services (based on dollars) than any other group of physician practice. In addition, beneficiaries had to have at least two E/M services at the group practice. CMS used this attributed population to identify a sample of beneficiaries eligible for the quality measures reported via the PQRS GPRO Web interface and also to calculate the per capita cost measures based on this attributed population. For groups of physicians reporting through the GPRO Web interface, CMS is considering whether to continue use of the "plurality of care" attribution methodology or to use the Medicare Shared Savings Program attribution methodology for 2013 and beyond.

In order to ensure program alignment, CMS favors the use of the "plurality of care" attribution method for groups of physicians. That is, CMS would calculate the per capita cost measures based on the same attributed beneficiary population it uses to determine the quality measures for group practices that participate in the PQRS. However, CMS is concerned that this attribution methodology may be too restrictive because it relies solely on office (E/M) visit codes and that it could exclude beneficiaries who the group practices would identify as their patients, e.g., groups that do not submit many claims with E/M codes.

The "degree of involvement" is a method that CMS has used to attribute beneficiaries for cost purposes to individual physicians in the CY 2010 physician feedback reports, under which CMS classified patients for whom a physician submitted at least one Medicare fee-for-service Part B claim into three categories (directed, influenced and contributed) based on the amount of physician involvement with the patient:

- For **directed** patients, the physician billed for 35 percent or more of the patient's office or other outpatient E/M visits.
- For **influenced** patients, the physician billed for fewer than 35 percent of the patient's outpatient E/M visits, but for 20 percent or more of the patient's total professional costs.
- For **contributed** patients, the physician billed for fewer than 35 percent of the patient's outpatient E/M visits and for less than 20 percent of the patient's total professional costs.

CMS seeks comment on whether to attribute populations of beneficiaries to groups of physicians using (1) a combination of the directed and influenced rules and (2) the contributed rule. That is, CMS would calculate one total per capita cost measure for the groups of physicians' "directed and influenced" beneficiaries and a second total per capita cost measure for the groups' "contributed" beneficiaries. CMS feels it's important to maintain the "contributed" category (i.e., those beneficiaries

that are neither directed nor influenced by other physicians) because the care of these beneficiaries is where the greatest potential for improved care and coordination reside.

Proposed Composite Scores

CMS is required under statute to evaluate quality of care and cost based on a composite of measures. CMS proposes to classify each of the quality measures proposed for the modifier into one of the six domains identified under the national quality strategy and to weight each domain equally to form a quality of care composite.

In terms of the cost composite, CMS would group the five per capita cost measures discussed earlier into two separate domains: total overall cost (one measure) and total costs for beneficiaries with specific conditions (four measures). If CMS attributes two patient populations to each group of physicians using the "degree of involvement" attribution methodology, it would weight the measures in each population based on the group of physicians' allowed charges for beneficiaries attributed to each population so that the cost composite accurately reflects the cost of care furnished.

View table: Relationship between Quality of Care and Cost Composites and the Value-Based Payment Modifier.

Since CMS is proposing to provide flexibility to groups of physicians in terms of the quality measures they report, the agency proposes a scoring approach that focuses on how the group of physicians' performance differs from the benchmark on a measure-by-measure basis. For each quality and cost measure, CMS proposes dividing the difference between a group of physicians' performance rate and the benchmark by the measure's standard deviation. The benchmarks are the national means of the quality or cost measure. This step would produce a score for each measure that is expressed in standardized units. Each measure's standardized score would be weighted equally with other measures in the domain to obtain the domain standardized score. The domain scores would then be weighted equally to form the quality of care and cost composites. View table that illustrates this approach.

Proposed Benchmarks and Peer Groups for Quality Measures

CMS proposes that the benchmark for each quality measure be the national mean of each measure's performance rate during the performance period. CMS proposes to unify the calculation of the benchmark by weighting the performance rate of each physician and group of physicians submitting data on the quality measure by the number of cases used to calculate the performance rate.

Proposed Benchmarks and Peer Groups for Cost Measures

To ensure fair cost comparisons that identify groups of physicians who are outliers (both high and low), CMS believes the same methodology should be used to attribute beneficiaries to the groups of physicians and to the groups of physicians in the peer group. Thus, CMS proposes that the peer group for the cost measures also be identified using the "plurality of care" attribution method.

Proposed Reliability Standard

CMS proposes a minimum case size of 20 for both quality and cost measures to ensure high statistical reliability. If that number is not met for a particular measure, the measure would not be counted in

the calculation of the value-based payment modifier and the remaining measures in the domain would be given equal weight.

Proposed Value-Based Payment Modifier Scoring Methodology

CMS developed two models that compare the quality of care furnished to costs: a quality tier model and a total performance score model. CMS proposes the quality-tiering model for the value-based payment modifier, but seeks comment on both models.

The **quality-tiering model,** which CMS appears to favor, compares the quality of care composite with the cost composite by classifying the quality of care composites scores into high, average and low quality of care categories based on whether they are statistically above, not different from or below the mean quality composite score. Likewise, 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 the mean cost composite score. CMS believes this approach would minimize the number of physician groups subject to payment adjustments.

To ensure that the value-based payment modifier does not prevent groups of physicians from treating the most difficult cases, CMS proposes a greater upward payment adjustment (+1.0x) for groups of physicians who care for high-risk patients (see table 70 below). For example, the upward payment adjustment would be increased to +3x (rather than +2x) for groups of physicians classified as high quality/low cost and to +2x (rather than +1x) for groups of physicians that are either high quality/average cost or average quality/low cost if the group of physicians' attributed patient population has an average risk score that is in the top 25 percent of all beneficiary risk scores.

Table 70: 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.*

The second approach, using a **total performance score model**, would allow CMS to develop a unique value-based payment modifier for each group of physicians, resulting in a range of continuous payment adjustments rather than the thresholds proposed in the quality tier approach. Under this approach, CMS would calculate a total performance score by equally weighting the quality of care and cost composites. A negative score for the quality and cost composites means the group of physicians performed below the national average (or above average for costs). A score of zero means that the group performed at the national average. CMS could then translate the total performance score into a unique value-based payment modifier for each group of physicians, similar to the linear approach used in the hospital value-based purchasing program, which results in a continuous array of unique value-based payment modifiers such that there are no cut-off points between high and low performing groups of physicians.

Proposed Payment Adjustment Amount

PPACA does not specify the amount of physician payment that should be subject to the adjustment for the value-based payment modifier. CMS acknowledged the other payment adjustments affecting physicians' Medicare payment in 2015 that could further decrease physician payments in 2016 (i.e., PQRS, EHR MU and eRx adjustments). As noted earlier, CMS proposes to separate groups of physicians with 25 or more eligible professionals into two categories, those who satisfactorily report PQRS measures and those that do not. For those groups of physicians who successfully report PQRS and request the quality-tiering approach, CMS proposes that the maximum payment adjustment be -1 percent for poor performance. Due to the budget neutrality requirement, CMS cannot propose the exact amount of the upward payment adjustments for high performance at this time. For groups of physicians that have not satisfactory reported or have not participated in PQRS, CMS proposes to set their value-based payment modifier at -1.0 percent.

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. Currently, the site includes basic information, such as location and specialty for physicians, group practice and hospital affiliations, education, languages spoken, and gender. The site also posts if physicians satisfactorily report data for PQRS and/or are successful electronic prescribers under the eRx incentive program. Proposals regarding the physician compare website include:

- CMS will implement a plan for making physician *performance* data on quality and patient experience publicly available.
- CMS will make public physician compare performance rates on the quality measures that group practices submit through the GPRO Web interface under the PQRS GPRO and the Medicare Shared Savings Program.
- For 2013, CMS will only 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).
- CMS proposes two options for when the agency will publicly report patient experience data on physician compare.
    - In option one, CMS proposes to publicly report, no earlier than 2014, the 2013 patient experience data for all group practices participating in the 2013 PQRS GPRO. CMS will administer and collect patient experience survey data on a sample of the group practices' beneficiaries.
    - As an alternative option, CMS is considering delaying public reporting of patient experience data on physician compare until program year 2014, which would be posted no earlier than 2015. CMS would provide confidential feedback to group practices and ACOs using 2013 patient experience data as a baseline, during which time the group practices and ACOs would have the opportunity to review their data and implement changes to improve patient experience scores.
- CMS proposes posting the names of physicians who earned a PQRS Maintenance of Certification Program incentive as data becomes available, but no sooner than 2014.
- CMS is considering allowing measures that have been developed and collected by approved and vetted specialty societies to be reported on physician compare, as deemed appropriate, and as they are found to be scientifically sound and statistically valid.

- CMS proposes publicly reporting performance rates on 2015 PQRS and value-based payment modifier quality measures for individual professionals. Public reporting of the 2015 individual data would occur no earlier than 2016.

Technical Correction

CMS proposes modifying its regulations to reflect a policy it previously finalized in CY2011 that waived the deductible for colorectal screening tests regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test.