



FACT SHEET

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Changes for Calendar Year 2014 Physician Quality Programs and the Value-Based Payment Modifier

OVERVIEW

On November 27, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that updates payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS) on or after Jan. 1, 2014. The rule also finalizes changes to several of the quality reporting initiatives that are associated with PFS payments, including the Physician Quality Reporting System (PQRS), as well as changes to the Physician Compare tool on the Medicare.gov website. Finally, the final rule includes provisions for implementing the value-based payment modifier (Value Modifier) required by the Affordable Care Act that will affect payments to certain groups of physicians based on the quality and cost of care they furnish to beneficiaries enrolled in the traditional Medicare Fee-for-Service program.

This fact sheet discusses the final policies adopted for these quality reporting programs and the continued phase-in of the Value Modifier. A separate fact sheet, also issued today, discusses the changes to payment policies for services furnished under the PFS.

PHYSICIAN QUALITY REPORTING SYSTEM

The Physician Quality Reporting System (PQRS) is a pay-for-reporting program that uses a combination of incentive payments and downward payment adjustments to promote reporting of quality information by eligible professionals (EPs). The program provides an incentive payment through 2014 to EPs and group practices who satisfactorily report data on quality measures for covered professional services furnished to Medicare Part B fee-for-service beneficiaries during the applicable reporting period. In lieu of satisfactory reporting, beginning in 2014, EPs may satisfy the PQRS by satisfactorily participating in a qualified clinical data registry. Beginning in 2015, a downward payment adjustment will apply to EPs who do not satisfactorily report data on quality measures for covered professional services.

In the CY 2014 PFS rule, CMS is finalizing the following updates to the PQRS:

Summary of Final PQRS Measures: For 2014, we are adding 57 new individual measures and 2 measures groups to fill existing measure gaps and plan to retire a number of claims-based measures to

encourage reporting via registry and EHR-based reporting mechanisms. Therefore, the PQRS will contain a total of 287 measures and 25 measures groups in 2014.

Reporting PQRS Measures as Individual EPs: CMS established certain requirements for the 2014 PQRS incentive, which is the final year that incentive payments may be earned under the PQRS, in the CY 2013 PFS final rule. However, we are finalizing certain changes and additions to these requirements, including the following:

- For certain reporting criteria, increasing the number of measures from 3 to 9 that must be reported via the claims and registry-based reporting mechanisms
- For certain satisfactory reporting criteria, changing the percent reporting threshold for reporting individual measures via registry to require that EPs report on 50% of the EP's applicable patients rather than 80%
- Eliminating the reporting option to report claims-based measures groups

As a result of the changes we are finalizing, in some cases, if an EP meets the criteria for satisfactory reporting for purposes of the 2014 PQRS incentive, the EP will also satisfy the reporting for the 2016 PQRS payment adjustment (in other words, by satisfying the same reporting criterion that applies to both the 2014 PQRS incentive and 2016 PQRS payment adjustment, EPs will earn a 2014 PQRS incentive and avoid the downward payment adjustment that is applied in 2016). In addition, we are retaining, but with some modifications, the criterion established in the CY 2013 PFS final rule that an EP using the claims and registry-based reporting mechanism may report 3 measures on 50% of the EP's applicable patients for the 2016 PQRS payment adjustment.

PQRS Reporting via Satisfactory Participation in a Qualified Clinical Data Registry:

The American Taxpayer Relief Act of 2012 allows EPs to be treated as satisfactorily submitting data on quality measures for covered professional services if the EP satisfactorily participates in a qualified clinical data registry.

- Under this clinical data registry option, EPs report the data on quality measures used by the qualified clinical data registry, including non-PQRS measures. EPs may report measures on all patients, regardless of whether or not they are Medicare Part B FFS patients. For the 2014 PQRS incentive, EPs participating in qualified clinical data registries may meet the criteria for satisfactory participation by reporting to the qualified clinical data registry at least 9 measures covering at least 3 of the NQS domains, and report each measure for at least 50% of the EP's applicable patients. At least one of the measures must be an outcome measure. For the 2016 PQRS payment adjustment, EPs participating in qualified clinical data registries need only report 3 measures covering 1 NQS domain for at least 50% of the EP's applicable patients.

Reporting PQRS Measures as a Group Practice under the Group Practice Reporting Option (GPRO):

In the CY 2013 PFS final rule, we finalized the requirements for meeting the criteria for satisfactory reporting under the GPRO using the registry, EHR, and GPRO web interface reporting mechanisms for

the 2014 PQRS incentive. However, in this final rule, we are making changes to certain criteria for satisfactory reporting, as well as adopting new criteria, for group practices for purposes of the 2014 PQRS incentive and 2016 PQRS payment adjustment, including the following:

- Adopting a new reporting mechanism, the certified survey vendor reporting mechanism, under which a group comprised of 25 or more EPs reports CG CAHPS survey measures in conjunction with other PQRS reporting mechanisms.
- Aligning the reporting criteria for group practices reporting individual measures via registry with the individual EP reporting criteria for the 2014 PQRS incentive and 2016 PQRS payment adjustment.

With this final rule, given the alignment of certain criteria, in some cases, the same criteria for satisfactory reporting under the GPRO apply for purposes of the 2014 PQRS incentive and the 2016 PQRS payment adjustment (in other words, group practices that meet the such criteria would earn the 2014 PQRS incentive and also avoid the downward payment adjustment that applies in 2016). Please note that group practices who are participating in the PQRS as an ACO in the Medicare Shared Savings Program must meet the requirements outlined for the Medicare Shared Savings Program for purposes of meeting the criteria for satisfactory reporting for the 2014 PQRS incentive and 2016 PQRS payment adjustment.

THE MEDICARE EHR INCENTIVE PROGRAM

We are finalizing additional options for eligible professionals (EPs) to report clinical quality measures (CQMs) under the Medicare EHR Incentive Program beginning in 2014.

Medicare EHR Incentive Program CQM Reporting Using Qualified Clinical Data Registries:

We are establishing an option for EPs to submit CQM information using qualified clinical data registries (as defined for PQRS) for purposes of meeting the CQM reporting component of meaningful use (MU) for the Medicare EHR Incentive Program beginning in 2014. Among other requirements for this reporting option, EPs would have to use certified EHR technology, as required under the Medicare EHR Incentive Program, and report on CQMs that were included in the EHR Incentive Program Stage 2 final rule.

Comprehensive Primary Care Initiative –Additional Group Reporting Option:

The Comprehensive Primary Care Initiative (CPCI), under the authority of Section 3021 of the Affordable Care Act, is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. The CPCI uses a subset of the CQMs finalized in the EHR Incentive Program Stage 2 final rule. In a continuing effort to align quality reporting programs and innovation initiatives, we are adding a group reporting option to the Medicare EHR Incentive Program beginning in CY 2014 for EPs who are part of a CPCI practice site that successfully submit at least 9 CQMs covering 3 domains. We are finalizing that each of the EPs in the CPCI practice site will satisfy the CQM reporting component of meaningful use if the practice site successfully submits and meets the reporting requirements of the CPCI.

Reporting of Electronically Specified Clinical Quality Measures for the Medicare EHR Incentive Program:

The electronic specifications for the clinical quality measures that were finalized under the Medicare EHR Incentive Program for use by EPs beginning in CY 2014 are updated annually to account for non-substantive issues such as changes in billing and diagnosis codes. We are finalizing the policy that EPs who seek to report clinical quality measures electronically under the Medicare EHR Incentive Program must use the most recent version¹ of the electronic specifications for the clinical quality measures and have certified EHR technology (CEHRT) that is tested and certified to the most recent version of the electronic specifications for the clinical quality measures. EPs who do not wish to report clinical quality measures electronically using the most recent version of the electronic specifications (for example, if their CEHRT has not been certified for that particular version) would be allowed to report clinical quality measure data to CMS by attestation for the Medicare EHR Incentive Program.

PHYSICIAN COMPARE WEBSITE

The final rule outlines the next phase of the plan to publicly report physician performance information on Physician Compare. For 2014, CMS finalized its proposal to publicly report all measures collected through the GPRO web interface for groups of all sizes participating in the 2014 PQRS GPRO and for ACOs participating in the Medicare Shared Savings Program. These data include measure performance rates for measures included in the 2014 PQRS GPRO web interface that met the minimum sample size of 20 patients, and that prove to be statistically valid and reliable. CMS will provide a 30-day preview period prior to publication of quality data on Physician Compare so that group practices and ACOs can view their data as it will appear on Physician Compare before it is publicly reported. We also finalized our proposal to publicly report certain measures that groups report via registries and EHRs in 2014 under the PQRS GPRO.

As part of our public reporting plan, in the 2013 PFS final rule, CMS also finalized our decision to publicly report Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) data for group practices of 100 or more eligible professionals reporting data in 2013 under the GPRO, and for ACOs participating in the Medicare Shared Savings Program. We anticipate posting these data on Physician Compare as early as 2014. For the 2014 PFS final rule, CMS has finalized its proposal to continue to publicly report CG-CAHPS data in 2014 on Physician Compare in 2015 for group practices with 100 or more eligible professionals participating in PQRS GPRO through the GPRO web interface. Finally, we are finalizing our proposal to publicly report CG-CAHPS data in 2014 on Physician Compare

¹ We are providing one exception to this rule for the measure CMS140v2, Breast Cancer Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer (NQF 0387) because an error was found in the June 2013 logic of this measure. The June 2013 version of this measure was posted on CMS's website on June 29, 2013. The error relates to the relative timing of the diagnosis of breast cancer and the diagnosis of ER or PR positive breast cancer. In clinical practice, a diagnosis of breast cancer should precede the more specific diagnosis of ER or PR positive breast cancer. The logic in CMS140v2 reverses this order. The expected impact of this error is that very few but most likely no patients will meet the denominator criteria. Therefore, if EPs want to report this measure electronically, we are requiring that EPs report on the measure CMS140v1, which is the prior, December 2012 version of the measure CMS140v2, Breast Cancer Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer (NQF 0387). To the extent that an EP reports another version of this measure other than CMS140v1, (for example, if their certified EHR technology includes the other version), we require EPs to report the other version by attestation.

in 2015 for ACOs reporting through the GPRO web interface or other CMS-approved tool or interface.

MEDICARE SHARED SAVINGS PROGRAM (SHARED SAVINGS PROGRAM)

ALIGNMENT WITH PQRS

To continue to align with PQRS, ACOs will report the ACO GPRO measures through a CMS web interface on behalf of eligible professionals and must meet the criteria for the 2014 PQRS incentive to satisfactorily report to avoid the 2016 PQRS payment adjustment.

BENCHMARKING

Previously, CMS indicated that we would use national Medicare Advantage data, national FFS Medicare data or a flat percentage to establish the quality performance benchmarks for the Shared Savings Program, and would seek to incorporate actual ACO performance into establishing quality benchmarks in future program years. We are now finalizing our proposals to use fee-for-service data, including data submitted by Shared Savings Program and Pioneer ACOs, to set the performance benchmarks for the 2014 and subsequent reporting periods. CMS did not finalize the proposal to use MA data alone or in combination with fee-for-service data in the short-term to set ACO performance benchmarks. Additionally, CMS will set benchmarks based on flat percentages when the 60th percentile is equal to or greater than 80.0 percent. Finally, we are finalizing our proposal to increase the scoring for the CG CAHPS survey measure modules within the patient experience of care domain that transition to pay-for-performance in the second year of an ACO's agreement period, so that these CAHPS survey measure modules will carry greater weight within the patient experience of care domain. Although the weight of some measure modules within the domain will increase, the domain itself will continue to represent 25% of the total quality performance score.

PHYSICIAN VALUE-BASED PAYMENT MODIFIER AND THE PHYSICIAN FEEDBACK PROGRAM

VALUE MODIFIER FOR ITEMS AND SERVICES PAID UNDER THE PFS

The Affordable Care Act requires us to establish a value-based payment modifier that provides for differential payment to a physician or group of physicians under the PFS based upon the quality of care furnished to Medicare beneficiaries compared to the cost of that care during a performance period. Further, the statute requires that we begin applying the value-based payment modifier on January 1, 2015, with respect to items and services furnished by specific physicians and groups of physicians (as determined by the Secretary) and to apply it to all physicians and groups of physicians beginning not later than Jan. 1, 2017.

By law, the value-based payment modifier must be implemented in a budget neutral manner, meaning that upward payment adjustments for high performance will balance the downward payment adjustments applied for poor performance. In this final rule, we finalize many of the proposed additions and refinements to the existing value-based payment modifier policies as applied to the CY 2016 value-based payment modifier. These policies continue our phased-in implementation of the value-based payment

modifier by reinforcing our emphasis on quality measurement, alignment with the PQRS, physician choice, and shared accountability. Specifically, this final rule includes the following policies:

Group Size

We are finalizing our proposal to lower the group size threshold from groups of physicians with 100 or more eligible professionals that are subject to the value-based payment modifier in CY 2015 to groups of physicians with 10 or more eligible professionals for 2016. We estimate that this policy would cause approximately 17,000 groups and nearly 60 percent of physicians to be included in the value-based payment modifier program in CY 2016.

Policies for Setting the Value-Based Payment Modifier Adjustment Based on PQRS Participation

We are finalizing the proposed two-category approach for establishing the CY 2016 value-based payment modifier based on whether a group of physicians meets the criteria to avoid the PQRS payment adjustment in CY 2016. Category 1 includes those groups of physicians with 10 or more eligible professionals that meet the satisfactory reporting criteria through the PQRS GPRO for the CY 2016 PQRS payment adjustment.

We proposed that if a group of physicians subject to the CY 2016 value-based payment modifier does not participate in the PQRS GPRO, to be included in Category 1, at least 70 percent of the eligible professionals billing under the group's Tax Identification Number (TIN) must meet the criteria for satisfactory reporting (or the criteria for satisfactory participation, if reporting to a PQRS qualified clinical data registry) for the CY 2016 PQRS payment adjustment. However, we are finalizing that at least 50 percent of the eligible professionals billing under the group's TIN must meet the criteria for satisfactory reporting (or satisfactory participation) for the CY 2016 PQRS payment adjustment in order to be included in Category 1. This policy allows EPs in those groups to continue to report data for the PQRS individually if they so choose. Groups of physicians with 10 or more eligible professionals that do not meet the criteria for inclusion in Category 1 will be in Category 2 and be subject to an automatic downward payment adjustment under the value-based payment modifier.

In addition, for the CY 2016 value-based payment modifier, we are finalizing our proposal to make quality-tiering (which is the method for evaluating performance on quality and cost measures for the value-based payment modifier) mandatory for groups of physicians with 10 or more EPs. We are also finalizing our proposal that groups of physicians with between 10 and 99 eligible professionals would not be subjected to a downward payment adjustment (that is, they will either receive an upward or neutral adjustment) determined under the quality-tiering methodology. Groups of physicians with 100 or more EPs, however, would either receive upward, neutral, or downward adjustments under the quality-tiering methodology. We believe this new approach to implementing quality-tiering will reward groups of physicians that provide high-quality/low-cost care, reduce program complexity, and more fully engage groups of physicians in our plans to implement the value-based payment modifier.

We also are finalizing our proposal to use for the CY 2016 value-based payment modifier all of the PQRS measures that would be available to be reported under the various PQRS reporting mechanisms in CY 2014, including quality measures reported by individuals EPs in a group through qualified clinical data registries, to calculate a group of physicians' value-based payment modifier in CY 2016 to the extent that

a group of physicians submits data on these measures. In addition, we are finalizing our proposal that groups of 25 or more eligible professionals would be able to elect to have the patient experience of care measures collected through the PQRS CG-CAHPS survey for CY 2014 included in their value-based payment modifier for CY 2016.

Value Modifier Payment Adjustments

We proposed to increase the maximum downward adjustment under the value-based payment modifier from 1.0 percent in CY 2015 to 2.0 percent for CY 2016. That is, for CY 2016, a -2.0 percent value-based payment modifier would apply to groups of physicians subject to the value-based payment modifier that fall in Category 2. In addition, we proposed to increase the maximum downward adjustment under the quality-tiering methodology to -2.0 percent for groups of physicians subject to the CY 2016 value-based payment modifier that fall in Category 1 and are classified as low quality/high cost and to set the adjustment to -1.0 percent for groups classified as either low quality/average cost or average quality/high cost. We are finalizing these policies as proposed.

Policy to Include the Medicare Spending per Beneficiary Measure in the Value-Based Payment Modifier Cost Composite

We proposed to include the Medicare Spending per Beneficiary (MSPB) measure as an additional measure in the cost composite of the value-based payment modifier beginning with CY 2016. The measure includes all Medicare Part A and Part B payments during an MSPB episode. An MSPB episode spans from 3 days prior to an index admission at a subsection (d) hospital through 30 days post discharge with certain exclusions. The MSPB measure is already included in the Hospital Inpatient Quality Reporting Program and in the Hospital-Value-based Purchasing Program. This measure would be included in the total per capita costs for all attributed beneficiaries domain along with the total per capita cost measure. Each measure would be weighted equally in the domain. We proposed not to convert the MSPB amount to a ratio as is done to compute a hospital's MSPB measure, but rather use the MSPB amount as the measure's performance rate. We are finalizing these policies as proposed because we believe it is essential to assess both hospitals and the physicians who provide services in them on the same measure to align incentives to provide high-quality, efficient care to beneficiaries.

We also proposed to attribute an MSPB episode to a group of physicians subject to the value-based payment modifier, when any eligible professional in the group bills a Part B Medicare claim for a service rendered during an inpatient hospitalization that is an index admission for the MSPB measure. However, we are finalizing a single attribution methodology where an MSPB episode is attributed to the group of physicians (as identified by the Taxpayer Identification Number) that furnished the plurality of Part B services during the index admission. This policy was favored by most commenters because it attributes responsibility for a beneficiary's hospitalization to one group of physicians.

We finalized our proposal that a group of physicians would have to be attributed a minimum of 20 MSPB episodes during the performance period to have their performance on this measure included in the value-based payment modifier cost composite. We believe that including the MSPB in the value-based payment modifier will help to align performance incentives across the delivery system.

Refinements to the Cost Measure Benchmarking Methodology

In the CY 2013 PFS final rule with comment period, we established a policy to create a cost composite for each group of physicians subject to the value-based payment modifier. We have since examined the distribution of the cost composite scores among all groups of physicians and solo practitioners to determine whether comparisons at the group level are appropriate once we apply the value-based payment modifier to smaller groups and solo practitioners. We found that our current peer grouping methodology could have varied impacts on different physician specialties. Thus, we proposed to refine our current peer group methodology to account for physician specialty mix. We are finalizing this policy proposal.

Performance Period for the 2017 Value-Based Payment Modifier

We believe it is important to notify physicians and groups of physicians of the performance period for the value-based payment modifier that will apply in CY 2017, when all physicians and groups of physicians will be subject to the value-based payment modifier. We are finalizing our proposal to use CY 2015 as the performance period for the application of the CY 2017 value-based payment modifier. We encourage all physicians in groups of less than 10 EPs and solo practitioners to use 2014 as a “practice” year with the PQRS quality reporting mechanism of their choice so that they are ready for the value-based payment modifier in 2015.

PHYSICIAN FEEDBACK PROGRAM

Since 2010, we have provided annual Quality and Resource Use Reports (QRURs) to physicians and groups of physicians to provide feedback on the quality of care furnished, and the cost of that care, to Medicare beneficiaries. We will continue to use the annual QRURs to explain how the value-based payment modifier would affect payment under the PFS. In September 2013, we made QRURs available to all groups of 25 or more eligible professionals nationwide, based on 2012 data. In 2014, we anticipate providing QRURs to all groups of eligible professionals and solo practitioners nationwide.

The final rule will be published in the December 10, 2013 Federal Register.

To view the final rule, see:

<http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1>

For more information on PQRS, visit: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>

For more information on the Medicare and Medicaid EHR Incentive Programs, visit: <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>

For more information on Physician Compare, visit: <http://www.medicare.gov/find-a-doctor/provider-search.aspx>

For more information on the Value-Based Payment Modifier and the Physician Feedback Program, visit: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html>

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