HHS | Hart Health Strategies

2014 Medicare Physician Fee Schedule Proposed Rule

Summary of Quality Provisions

Overview

On July 8, 2013, the Centers for Medicare and Medicaid Services (CMS) released the 2014 Medicare Physician Fee Schedule (MPFS) proposed rule, which proposes significant changes to the physician fee schedule and other Medicare Part B payment policies to reflect changes in medical practice and the relative value of services, as well as changes in the statute. In addition, the proposed rule outlines changes to several quality improvement programs, including the Physician Quality Reporting System (PQRS), the Physician Resource-Use Feedback Program and the Value-Based Payment Modifier (VBM), the Medicare Electronic Health Record (EHR) Incentive Program, and the Physician Compare Website, among other Part B related issues. Comments on the proposals are due September 6, 2013.

This summary highlights proposals related to the quality provisions in the rule. Page numbers referenced correlate to the display version of the MPFS found on the Federal Register website.

Quality Provisions of the 2014 MPFS Proposed Rule

Physician Compare Website (pg. 266)

As required by the ACA, CMS continues to use rulemaking and other means of stakeholder outreach to determine quality measures it should report via Physician Compare. CMS reports on its efforts to date to improve the site in response to public feedback, including an overhaul of the underlying database and improved search functions. While the primary source of administrative information on Physician Compare is the Provider Enrollment, Chain, and Ownership System (PECOS), CMS now incorporates Medicare claims information to verify the information in PECOS and to ensure the most current and accurate information. Specialties are defined by the 855i Medicare Enrollment Form. Currently, and as required by statute, the site identifies individuals and group practices that have satisfactorily reported under PQRS or the e-Prescribing Program and individuals who participate in the Medicare EHR Incentive Program. Starting with data reported for CY 2013, the site will indicate who qualified for the PQRS Maintenance of Certification Additional Incentive. CMS also notes that work is under way to prepare a report to Congress prior to the January 2015 statutory deadline on Physician Compare development.

Public Reporting of Group Practice Data. For 2014, CMS proposes to expand public reporting to all measures collected through the GPRO web interface for groups of all sizes participating in the 2014 PQRS GPRO and for Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program. CMS had previously decided to publicly report GPRO measures groups related to diabetes and coronary artery disease only. The data reported in 2014 would include performance rates for measures included in the 2014 PQRS GPRO web interface that meet the minimum sample size of 20 patients, and that prove to be statistically valid and reliable. As previously finalized, 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 before it is publicly reported.

CMS also proposes to publicly report, no earlier than 2015, performance on certain measures that group practices report under the GPRO via registries and EHRs in 2014, including:

- Diabetes: Hemoglobin A1c Poor Control
- Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- Medication Reconciliation
- Preventive Care and Screening: Influenza Immunization
- Pneumococcal Vaccination Status for Older Adults
- Preventive Care and Screening: Breast Cancer Screening
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
- Colorectal Cancer Screening
- Coronary Artery Disease (CAD): Angiotensin-converting Enzyme Inhibitor or Angiotensin Receptor Blocker Therapy -- Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)
- CAD: Lipid Control
- Adult Weight Screening and Follow-Up
- Preventive Care and Screening: Screening for Clinical Depression
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- IVD: Complete Lipid Panel and LDL Control
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Hypertension (HTN): Controlling High Blood Pressure

For EHR reporting, publicly reported measures would include:

- Diabetes: Hemoglobin A1c Poor Control
- HF: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- Preventive Care and Screening: Influenza Immunization
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
- Preventive Care and Screening: Breast Cancer Screening
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Pneumococcal Vaccination Status for Older Adults
- Colorectal Cancer Screening
- Adult Weight Screening and Follow-Up
- CAD: Lipid Control
- IVD: Use of Aspirin or Another Antithrombotic
- Hypertension (HTN): Controlling High Blood Pressure
- IVD: Complete Lipid Panel and LDL Control

In 2013, CMS also began to collect patient experience survey data for group practices participating in the GPRO and ACOs using the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey. CMS intends to publicly report these measures on Physician Compare in 2014 for data collected for CY 2013 for ACOs and group practices with 100 or more eligible professionals (EPs) reporting through the GPRO web interface. CMS will administer and fund the collection of this data on a sample of the group's patients.
For group practices, these measures would include:

- CAHPS: Getting Timely Care, Appointments, and Information
- CAHPS: How Well Your Doctors Communicate
- CAHPS: Patients' Rating of Doctor
- CAHPS: Access to Specialists
- CAHPS: Health Promotion and Education

For ACOs, these same five measures would be reported, plus the following:

- CAHPS: Shared Decision Making
- CAHPS: Health Status/Functional Status

CMS believes the CG-CAHPS is a well-tested, accurate and useful tool and seeks comments on its proposal to make the aforementioned measures available for reporting through the PQRS and for the Value Based Modifier (VBM), as well as to publicly report CY 2014 CG-CAHPS data for groups of 25 or more EPs that voluntarily chooses to report CG-CAHPS. However, CMS will not fund the surveys for these groups and will only report on data collected via a certified CAHPS vendor (see discussion below).

Public Reporting of Individual Data. CMS also proposes to publicly report performance data collected for the CY 2014 PQRS via claims, EHR or registry from *individual* EPs as early as CY 2015. Applicable measures would include:

- Diabetes: Hemoglobin A1c Poor Control
- Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control
- Diabetes Mellitus: High Blood Pressure Control
- Diabetes Mellitus: Hemoglobin A1c Control (<8%)
- HF: Beta-Blocker Therapy for LVSD
- Medication Reconciliation
- Preventive Care and Screening: Influenza Immunization
- Preventive Care and Screening: Breast Cancer Screening
- Preventive Care and Screening: Screening for Clinical Depression
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
- Pneumococcal Vaccination Status for Older Adults
- Colorectal Cancer Screening
- CAD: ACE Inhibitor or ARB Therapy -- Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)
- CAD: Lipid Control
- Adult Weight Screening and Follow-Up
- IVD: Use of Aspirin or Another Antithrombotic
- IVD: Complete Lipid Panel and LDL Control
- HTN: Controlling High Blood Pressure
- Falls: Screening for Fall Risk
- Cardiovascular Prevention measures group, in support of the Millions Hearts Initiative

CMS also seeks comment on publicly reporting on patient experience performance data for individual physicians starting with data collected for CY 2015. In future years, it will consider expanding public reporting individual performance data on measures that have been developed and collected by approved specialty societies, as well as data collected via the new qualified clinical data registry option proposed under the PQRS. CMS also seeks comment on publicly reporting participation by individual professionals on initiatives such as Choosing Wisely.

Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System (pg. 282)

The PQRS provides a 0.5% incentive payment through 2014 to EPs and group practices who satisfactorily report data on quality measures. Beginning in 2015, a downward payment adjustment will apply to EPs who do not satisfactorily report data on quality measures. CMS reiterates that alignment of federal quality programs is critical to decreasing physician burden and allowing them to spend more time and resources on patients. In an effort to decrease burden and duplicative reporting requirements and to increase engagement, CMS proposes to change some previously finalized aspects of the 2014 PQRS incentive and 2016 PQRS payment adjustment, and the PQRS measure set.

Proposed Requirements for PQRS Reporting Mechanisms (p. 286)

Registry-based Reporting Mechanism. CMS previously finalized the requirement for registries to become qualified to participate in PQRS for 2013 and beyond. Since CMS is proposing to increase the number of measures that must be reported under the PQRS, it proposes to add to these requirements the ability of a registry to collect all of the data elements associated with these measures.

Certified Survey Vendors. In regards to CMS' proposal to allow groups of 25 or more to report CG-CAHPS measures (see below), CMS proposes a new reporting mechanism—transmitting data through a CMS certified survey vendor. A group practice choosing to report these measures would be required to select an additional reporting mechanism to meet the other requirements for satisfactory reporting for both the 2014 PQRS incentive and the 2016 PQRS payment adjustment. CMS proposes that vendors would be required to undergo training, to meet CMS standards on how to administer the survey, to submit a quality assurance plan, and to administer the survey according to established protocols to ensure valid and reliable results.

Proposed Changes to Individual Reporting Criteria for the 2014 PQRS Incentive (p. 288)

CMS proposes to increase from 3 to 9 the number of measures an EP must report via the claims-based reporting mechanism or via a qualified registry over the 12-month reporting period. These measures must cover at least 3 of the 6 National Quality Strategy (NQS) domains (person and caregiver-centered experience/outcomes; patient safety; communication/care coordination; community/population health; efficiency/cost reduction; effective clinical care). Given this increase in reporting and to ensure alignment with claims-based reporting, CMS proposes to reduce the reporting threshold for registry reporting from 80 to 50%. If less than 9 measures apply, the professional would have to report 1 to 8 measures, each for at least 50% of applicable Medicare Part B FFS patients seen during the reporting period. Measures with a 0% performance rate would not be counted. Those who report fewer than 9 measures under the claims-based mechanism would be subject to the Measures Applicability Validation (MAV) process to determine whether that professional should have reported quality data codes for additional measures.

The decision to increase the PQRS reporting requirement was due to CMS' need to collect more quality measures data to more accurately capture patient care, especially since this data may be used to evaluate a professional's performance under the VBM. These proposed claims and registry reporting requirements also would align with established reporting criteria for the EHR-based reporting mechanism for the 2014 PQRS incentive.

Proposed Changes to Measures Groups Reporting via Claims for Individual EPs for the 2014 PQRS Incentive (p. 293)

Due to infrequent usage of the claims-based measures group reporting mechanism, CMS proposes to eliminate this option. Therefore, the only way to report a PQRS measures group for the 2014 incentive would be via registry.

Proposed Reporting Criteria for the 2016 PQRS Payment Adjustment for Individual EPs using Claims and Registries (p. 294)

For 2016 and subsequent years, the payment adjustment is -2.0%. CMS previously finalized seven different criteria for individual reporting to avoid the 2016 PQRS payment adjustment. In this rule, CMS proposes the following changes:

- Remove the criterion to report at least 1 measures group for at least 20 Medicare Part B FFS patients
- Remove the criterion to report at least 3 measures for at least 80% of applicable Medicare Part B FFS patients. CMS would retain the requirement that EPs using the claims-based reporting mechanism

report on 3 measures for 50% of applicable patients in 2014 in order to avoid the 2016 PQRS payment adjustment.

- For claims-based and registry-based reporting of individual measures for the 2014 PQRS incentive, report at least 9 measures, covering at least 3 of the NQS domains over a 12-month reporting period.
- EPs that meet the criteria for the 2014 PQRS incentive would automatically avoid the downward payment for 2016.

As a result of these changes, there would be one more criterion for avoiding the 2016 payment adjustment than for the 2014 PQRS incentive with respect to claims-based reporting, but the other criteria would otherwise align. Despite the additional flexibility given to those trying to avoid the penalty, CMS notes that as it moves forward, it intends to ramp up the criteria for satisfactory reporting for the 2017 PQRS payment adjustment to be on par or more stringent than the criteria for satisfactory reporting for the 2014 PQRS incentive.

Proposals Related to Satisfactory Participation in a Qualified Clinical Data Registry by Individual EPs for the 2014 Incentive and 2016 PQRS Adjustment (p. 297)

The American Taxpayer Relief Act (ATRA) of 2012 provides for a new standard for individual EPs to satisfy the PQRS beginning in 2014, based on satisfactory participation in a qualified clinical data registry in lieu of reporting on traditional PQRS measures. In February 2013, CMS solicited public feedback, which it used to draft this section of the rule.

The term "qualified clinical data registry" refers to registries that may submit data in lieu of traditional PQRS measures (i.e., those that submit PQRS measure data to CMS under existing reporting mechanisms). CMS clarified that it is possible for an entity to serve as a traditional, qualified registry and qualified clinical data registry under the PQRS.

CMS also proposes "satisfactory participation" as a new standard under the PQRS and a substitute for the underlying standard of "satisfactory reporting" of quality data.

To qualify for the 2014 PQRS incentive and avoid the 2016 PQRS payment adjustment using this new reporting option, EPs would be required to report to a qualified clinical data registry on 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. Under the qualified registry option, at least one of the measures also must be an outcome measure. CMS aims to give EPs the flexibility to choose measures that are the most relevant to their practice by proposing to require that measures reported under this option come from one or more of the following sets: CG-CAHPS; NQF endorsed measures; current PQRS measures; measures used by boards or specialty societies; and measures used in regional quality collaboratives. Under this option, EPs may also report on all patients, regardless of payer source (i.e., not restricted to Medicare FFS, unlike the proposed criteria for reporting on individual PQRS quality measures, which requires the reporting of at least one Medicare patient). CMS recognizes that EPs who participate in a clinical registry will be doing more than just reporting quality data for PQRS purposes and notes that it expects the criteria for this option to further depart from the traditional PQRS reporting criteria as it gains more experience with the capabilities of clinical registries.

CMS proposes a 12-month reporting period of January 1, 2014 through December 31, 2014, to qualify for the 2014 PQRS incentive and to avoid the 2016 penalty. In future years, CMS may propose alternative reporting periods that could occur closer in time to the application of the PQRS payment adjustment.

Proposed Definition/Requirements for a Qualified Clinical Data Registry (p. 298). CMS defines a "qualified clinical data registry" for purposes of the PQRS as a "CMS-approved entity (such as a registry, certification board, collaborative, etc.) that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care furnished to patients."

CMS proposes multiple requirements for an entity to be considered a qualified clinical data registry, which are outlined in **Appendix A** of this summary.

The qualified registry would be required to submit data no later than the last Friday occurring 2 months after the end of the respective reporting period (i.e., February 27, 2015 for reporting periods occurring in 2014). CMS also proposes that, if a qualified registry is submitting measures data on behalf of individual EPs that are part of the same group practice (but not participating in the PQRS GPRO), the qualified clinical data registry would have the option to report the quality measures data to CMS in a batch containing data for each of the individual EPs within the group practice, rather than submitting individual files for each EP.

Should CMS find, pursuant to an audit, that a registry has submitted inaccurate data, CMS proposes to disqualify the registry for purposes of the PQRS for the following year. The entity must again become a qualified registry before it may submit quality measures data for purposes of the PQRS. The inaccurate data collected also would be discounted for purposes of an individual professional meeting PQRS reporting criteria.

In lieu of accepting quality measures data for the 2014 reporting period, CMS is accepting comments on an alternative approach under which a qualified registry would only have to provide CMS with a list of EPs (i.e., respective TIN/NPI information) that it believes have met the criteria for satisfactory participation in the registry. CMS considered this alternative because it does not have experience collecting data from clinical data registries, is unfamiliar with the type of clinical data registries collect, and is still building its data infrastructure.

Proposed Process for Being Designated as a Qualified Clinical Data Registry (p. 311). An entity must submit a self-nomination statement that indicates its intent to participate in PQRS as a qualified clinical data registry. CMS proposes that the self-nomination statement contain contact information; measure title, description, and specifications for each measure the qualified clinical data registry would require its EPs to report for purposes of participating in PQRS; and the rationale and evidence basis to support each of these measure

CMS proposes that these self-nomination statements be received by January 31 of the year in which the clinical data registry seeks to be qualified (that is, January 31, 2014 for purposes of becoming a qualified registry for the 2014 PQRS incentive and 2016 PQRS payment adjustment). CMS recognizes this is an early, but feels it is necessary to ensure the entity meets the basic requirements and to give EPs sufficient time to view a list of qualified registries a year prior to the end of the applicable reporting period. CMS anticipates posting a list of the entities that are designated by CMS as qualified clinical data registries in the fall of the same year.

Since the requirements will likely change over the initial years, CMS proposes that entities self-nominate annually. In the future, it anticipates moving towards a 2-year self-nomination process as the requirements for qualified clinical data registries are more firmly established.

Proposed Criteria for Satisfactory Reporting for the 2014 PQRS Incentive and 2016 Payment Adjustment for Group Practices in the GPRO (p. 322 and 326 respectively).

As previously finalized, group practices that meet the criteria for the 2014 PQRS incentive will automatically avoid the downward payment adjustment for 2016. CMS proposes to change the deadline for group practices to register to participate in the PQRS GPRO to September 30 rather than October 15 of the reporting year, starting with 2014. This will give CMS more time to pull samples to populate the GPRO web-interface.

Due to low participation rates this year and the ability of only larger practices to report on more varied population, CMS also proposes to eliminate the GPRO web interface reporting option for group practices of 25 to 99 EPs. That is, only groups with 100 or more EPs could use the GPRO web interface for the 2014 PQRS incentive.

For the 2014 incentive and 2016 adjustment, CMS also proposes to increase the criteria for reporting individual quality measures under the GPRO from at least 3 measures for at least 80% of the group practice's relevant Medicare patients to at least 9 measures covering at least 3 of the NQS domains for at least 50% of applicable patients. CMS also proposes to increase the requirement for registry reporting for groups with 2 or more EPs to include 9 measures covering 3 domains for at least 50% of applicable patients. Furthermore, CMS proposes to add a new reporting mechanism for group practices with 25 or more EPs to report CG-CAHPS survey measures, along with 6 other PQRS measures covering 2 NQS domains. The survey would be administered following the close of the PQRS registration period by a certified survey vendor for a sample of the group's assigned beneficiaries, and CMS would provide each group with a detailed report about the results of the survey. CMS proposes to assign beneficiaries to a group practice using plurality of primary care methodology, which it uses for the GPRO web interface. The agency acknowledges that this assignment methodology makes the survey an inappropriate option for non-primary care groups such as surgeons.

As a result of these proposed changes, the criteria for satisfactory reporting under the GPRO for the 2014 PQRS incentive and the 2016 PQRS payment adjustment would align so that a group practice could avoid the 2016 adjustment by meeting any of the criteria for the 2014 incentive.

The tables below summarize the individual and group reporting mechanisms being proposed for the 2014 incentive and 2016 adjustment.

TABLE 24: Summary of Proposals for the 2014 PQRS Incentive:
Proposed Criteria for Satisfactory Reporting of Individual Quality Measures (p. 321)

Reporting Period	Measure Type	Reporting Mechanism	Proposed Reporting/Participation Criteria
12-month (Jan 1 — Dec 31)	Individual Measures	* Claims	Report at least 9 measures covering at least 3 of the NQS domains OR If less than 9 measures apply to the eligible professional, then the eligible professional must report 1-8 measures for which there is Medicare patient data AND Report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.
12-month (Jan 1 — Dec 31)	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the NQS domains 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 would not be counted.
12-month (Jan 1 — Dec 31)	Measures selected by Qualified Clinical Data Registry	Qualified Clinical Data Registry	Report at least 9 measures available for reporting under a qualified clinical data registry covering at least 3 of the NQS domains, AND Report each measure for at least 50% of the eligible professional's patients. Of the measures reported via a clinical data registry, the eligible professional must report on at least 1 outcome measure.

***Subject to MAV process**

TABLE 25: Summary of Proposals for the 2016 PQRS Payment Adjustment:
Proposed Criteria for Satisfactory Reporting of Individual Quality Measures (p. 322)

Reporting Period	Measure Type	Reporting Mechanism	Proposed Reporting/Participation Criteria
12-month (Jan 1 — Dec 31)	Individual Measures	* Claims	Report at least 9 measures covering at least 3 of the NQS domains OR If less than 9 measures apply to the eligible professional, then the eligible professional must report 1-8 measures for which there is Medicare patient data AND Report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies.
12-month (Jan 1 — Dec 31)	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the NQS domains 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 would not be counted.
12-month (Jan 1 — Dec 31)	Measures selected by Qualified Clinical Data Registry	Qualified Clinical Data Registry	Report at least 9 measures available for reporting under a qualified clinical data registry covering at least 3 of the NQS domains AND Report each measure for at least 50% of the eligible professional's patients. Of the measures reported via a clinical data registry, the eligible professional must report on at least 1 outcome measure.

*Subject to the MAV process.

TABLE 26: Summary of Proposals for the 2014 PQRS Incentive:
Proposed Criteria for Satisfactory Reporting of Data on PQRS Quality Measures via the GPRO (p. 329)

Reporting Period	Reporting Mechanism	Group Practice Size	Proposed Reporting Criteria
12-month (Jan 1 — Dec 31)	Qualified Registry	2+ EPs	Report at least 9 measures covering at least 3 of the NQS domains AND Report each measure for at least 50% of the group practice's applicable 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)	Certified Survey Vendor + Qualified Registry, direct EHR	25+ EPs	Report all CG CAHPS survey measures via certified survey vendor AND Report at least 6 measures covering at least 2 of the NQS domains using the qualified registry, direct EHR product, EHR data submission

TABLE 27: Summary of Proposals for the 2016 PQRS Payment Adjustment:
Proposed Criteria for Satisfactory Reporting of Data on PQRS Quality Measures via the GPRO (p. 330)

Reporting Period	Reporting Mechanism	Group Practice Size	Proposed Reporting Criteria
12-month (Jan 1 — Dec 31)	Qualified Registry	2 + EPs	Report at least 9 measures covering at least 3 of the NQS domains AND Report each measure for at least 50% of the group practice's applicable 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)	Certified Survey Vendor + Qualified Registry, direct EHR product, EHR data submission vendor, or GPRO web Interface	25+ EPs	Report all CG CAHPS survey measures via certified survey vendor AND Report at least 6 measures covering at least 2 of the NQS domains using the qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface reporting mechanisms.

Selection of PQRS Quality Measures for 2013 Reporting and Beyond for Individual EPs and Group Practices (p. 330)

While CMS is statutorily required to consider and use, where available, measures endorsed by a consensus organization, the statute is silent regarding how these measures should be developed. CMS states that it does not believe there needs to be any special restrictions on the type or make-up of the organizations developing physician measures, such as restricting the initial development to physician-controlled organizations. CMS further notes that any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards for purposes of the PQRS.

Proposed PQRS Quality Measures for 2014 and Beyond (p. 333)

For 2014, CMS proposes to add 47 new individual measures and 3 measures measure groups to fill existing measure gaps and to retire a number of claims-based measures to encourage reporting via registry and EHR-based reporting mechanisms. All measures are classified against six NQS domains.

With respect to the PQRS EHR measures that are also reportable under the EHR Incentive Program (i.e., electronically specified clinical quality measures), CMS notes that the EHR Incentive Program may accept versions of electronically specified clinical quality measures that may be outdated. It also points out that once direct EHR products and EHR data submission vendors are issued a 2014 Edition certification for clinical quality measures, they will not necessarily be required to have such technology retested and recertified against the most recent, updated version of a clinical quality measure when such versions are made available. Nevertheless, CMS proposes that EPs must use the most recent, updated version of a clinical quality measure for purposes of the PQRS (e.g., for 2014 reporting, CMS would only accept measures that are e-specified using the versions that were updated and posted on June 2013, available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html). CMS also proposes that for purposes of the PQRS, the EP must use a direct EHR product or EHR data submission vendor that has been tested and certified to the most recent, updated version of clinical quality measure electronic specifications for PQRS purposes. CMS seeks comments on these two proposals.

Proposed Individual PQRS Measures and Measures within Measures Groups Available for Reporting for 2014 and Beyond (p. 337)

Proposed PQRS Core Measures Available for Reporting for 2014 and Beyond

In addition to the HHS Million Hearts Measures that CMS previously finalized as a recommended set of core measures for the PQRS, it also proposes to include additional measures listed below and in Table 28 (p. 338) as recommended core measures for 2014 and beyond. These measures were also finalized as recommended core measures in the EHR Incentive Program for 2014 and include:

Recommended Adult Core CQMs

- **Hypertension (HTN): Controlling High Blood Pressure (**Effective Clinical Care)
- **Use of High-Risk Medications in the Elderly (**Patient Safety)
- **Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (**Community/Population Health)
- **Use of Imaging Studies for Low Back Pain (**Efficiency and Cost Reduction)
- **Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (**Community/Population Health)
- **Documentation of Current Medications in the Medical Record (**Patient Safety)
- **Preventive Care and Screening: Body Mass Index Screening and Follow-Up (**Community/Population Health)
- **Closing the referral loop: receipt of specialist report (**Communication and Care Coordination)
- **Functional status assessment for complex chronic conditions (**Person and Caregiver-Centered Experience and Outcomes)

Recommended Pediatric Core CQMs

- **Appropriate Testing for Children with Pharyngitis (**Efficiency and Cost Reduction)
- **Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (**Community/Population Health)
- **Chlamydia Screening for Women (**Community/Population Health)
- **Use of Appropriate Medications for Asthma (**Effective Clinical Care)
- **Childhood Immunization Status (**Community/Population Health)
- **Appropriate Treatment for Children with Upper Respiratory Infection (**Efficiency and Cost Reduction)
- **Follow-Up Care for Children Prescribed Attention- Deficit/Hyperactivity Disorder Medication (**Effective Clinical Care)

- **Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (**Community/Population Health)
- **Children who have dental decay or cavities (**Effective Clinical Care)

Proposed Individual PQRS Measures (p. 343)

Table 29 (p. 344) contains the measures CMS is proposing to include in the PQRS for reporting via claims, registry or EHR beginning in 2014. This table also indicates other federal quality programs the measure is used for and describes CMS' rationale for proposing each measure. Included on this list are the following measures, which are not NQF-endorsed, but fill a measurement gap identified by CMS:

- **Screening Colonoscopy Adenoma Detection Rate Measure (**ACGAGA/ASGE)
- **HRS-3: Implantable Cardioverter- Defibrillator (ICD) Complications Rate (**HRS)
- **Patient-Centered Surgical Risk Assessment and Communication: The Percent of Patients who Underwent Non-Emergency Major Surgery Who Received Preoperative Risk Assessment for Procedure-Specific Postoperative Complications using a Data-Based, Patient-Specific Risk Calculator, and who also Received a Personal Discussion of Risks with the Surgeon (**ACS)

In Table 30 (p. 402), CMS specifies the measures it proposes to remove from reporting under the PQRS, including:

- **Hepatitis C: Antiviral Treatment Prescribed (**AMA PCPI): Measure lost NQF Endorsement/Measure Owner Support.
- **Hepatitis C: Counseling Regarding Risk of Alcohol Consumption (**AMA PCPI): Measure lost NQF Endorsement/Measure Owner Support.
- **Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy (**AMA PCPI): Measure lost NQF Endorsement/Measure Owner Support.
- **HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy (**AMA PCPI/NCQA): Measure lost NQF Endorsement/Measure Owner Support.
- **HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy (**AMA PCPI/NCQA): Measure lost NQF Endorsement/Measure Owner Support.
- **Hepatitis C: Hepatitis B Vaccination in Patients with HCV (**AMA PCPI): Measure lost NQF Endorsement/Measure Owner Support.
- **Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation (**AMA PCPI/ACCF/AHA): Measure lost NQF Endorsement/Measure Owner Support.
- **Ischemic Vascular Disease: Blood Pressure Management (NCQA):** Duplicative measures within PQRS.
- **HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis (**AMA PCPI/NCQA): Measure owner combined this measure with NQF 0409
- **Hypertension: Blood Pressure Measurement (**AMA-PCPI): Deleting to align with the measures available under the EHR Incentive Program, which does not have this measure available for reporting in 2014.
- **Hypertension: Blood Pressure Management (**AMA PCPI/ACCF/AHA): Deletion due to duplicative measures within PQRS.
- **Anticoagulation for Acute Pulmonary Embolus Patients (ACEP): Measure lost owner support.**
- **Smoking and Tobacco Use Cessation, Medical Assistance (NCQA):** Deleting to align with the measures available under the EHR Incentive Program, which does not have this measure available for reporting in 2014.
- **Diabetes Mellitus: Hemoglobin A1c Control (< 8%) (NCQA):** Deleting to align with the measures available under the EHR Incentive Program, which does not have this measure available for reporting in 2014.
- **Participation by a Hospital, Physician or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality (OFMQ):** Due to the proposed inclusion of Qualified Clinical Data Registries, this measure is redundant.
- **Osteoporosis Measures Group** (ABIM): Deleting due to the amount of measures that have duplicative medical concepts within the PQRS program.
- **Preventive Cardiology Composite Measures Group (ABIM):** Deleting due to the amount of measures that have duplicative medical concepts within the PQRS program.

Proposed PQRS Measures Groups (p. 424)

For 2014, CMS proposes to increase the minimum number of measures that may be reported in a measures group from 4 to 6. In doing so, it will add additional measures to measures groups that previously contained less than 6 measures. CMS did not think it was fair to raise the minimum to 9, which would be consistent with the

proposed reporting requirement for individual measures, since an EP must report ALL measures contained in a measures group versus being able to report on any 9 measures of their choosing when reporting measures individually.

Tables 31 through 56 (pgs. 426-451) specify the proposed measures groups for 2014, including additions to previously established groups. Three new measure groups are being proposed, which are:

- **Optimizing Patient Exposure to Ionizing Radiation**: Includes measures collecting data for standardized nomenclature, count of high dose radiation, reporting to a radiation dose index registry, availability of CT images for follow-up/ comparison, and search of CT images through a secure, authorized, media-free, shared archive, and CT follow-up for incidental pulmonary nodules.
- **General Surgery**: Incudes procedures such as ventral hernia, appendectomy, AV fistula, cholecystectomy, thyroidectomy, mastectomy, lymphadenectomy, sentinel lymph node biopsy (SLNB), or lumpectomy/breast biopsy.
- **Gastrointestinal Surgery**: Could be reported by specialized general surgical eligible professionals that focus on bariatric and colectomy procedures.

Proposed Reporting Mechanism Changes to PQRS Individual Measures for 2014 and Beyond (p. 452). CMS proposes that the following measures would no longer be reportable through the claims-based reporting mechanism:

- **Asthma: Assessment of Asthma Control – Ambulatory Care Setting**: Claims data indicates that a low threshold of EPs reported this measure, which is contained in the asthma measures group.
- **Asthma: Pharmacologic Therapy for Persistent Asthma - Ambulatory Care Setting**: in order to be able to use the MAV with this measure, CMS needed to align it with the other asthma measure.
- **Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment**: Claims data indicates that a low threshold of EPs reported this measure. Also, CMS believes there are still a sufficient amount of measures for these EPs to report via claims.
- **Hepatitis C: Counseling Regarding Risk of Alcohol Consumption**: For the same reasons cited above.
- **Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy**: For the same reasons cited above.
- **Antibiotic Treatment for Adults with Acute Bronchitis**: Avoidance of Inappropriate Use: For the same reasons cited above.
- **Diabetic Foot and Ankle Care, Peripheral Neuropathy- Neurological Evaluation**: For the same reasons cited above.
- **Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear**: For the same reasons cited above.
- **Rheumatoid Arthritis**: Tuberculosis Screening: For the same reasons cited above.
- **Rheumatoid Arthritis: Periodic Assessment of Disease Activity**: For the same reasons cited above.
- **Rheumatoid Arthritis: Functional Status Assessment**: For the same reasons cited above.
- **Rheumatoid Arthritis: Assessment and Classification of Disease Prognosis**: For the same reasons cited above.

Clinician Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) Survey (p. 457). CMS previously proposed that group practices of 25 or more EPs would have the option to complete the CG-CAHPS survey for purposes of satisfying the 2014 PQRS incentive and 2016 PQRS payment adjustment. Seven of the 12 measures are already used in the Medicare Shared Savings Programs; the remaining 7 address high importance areas. The group practice would bear the cost of having this survey administered. CMS continues to seek public comment on these proposed measures, which include:

- Getting timely care, appointments, and information;
- How well providers communicate;
- Patient's rating of provider;
- Access to specialists;
- Health promotion & education;
- Shared decision making;
- Health status/functional status;
- Courteous and helpful office staff;
- Care coordination;
- Between visit communication;
- Helping your to take medication as directed; and

- Stewardship of patient resources

The Selection of PQRS Measures for Satisfactory Participation in a Qualified Clinical Data Registry for 2014 and Beyond for Individual EPs (p. 458). Exercising authority granted under the ATRA of 2012, CMS proposes to provide qualified clinical data registries flexibility to determine the quality measures participating EPs would choose to have reported to CMS. CMS believes these registries know best what measures should be reported to achieve the goal of improving the quality of care furnished by their EPs. To ensure it uniform data and analyses, CMS proposes the following parameters for qualified clinical data registries:

- Must have at least 9 measures, covering at least 3 of the 6 NQS domains, available for reporting.
- Must have at least 1 outcome measure available for reporting, which measures the results of care experienced by patients (i.e., clinical events; recovery and health status; experiences in the health system; and efficiency/cost).
- May report on process measures that have a scientific basis for increasing the probability of achieving a desired outcome.
- Outcome and process measures reported must contain numerator and denominator data, and exceptions and exclusions, where appropriate.
- Must provide CMS with descriptions of the measures (numerator, denominator, exceptions, exclusions) that it will report to CMS by no later than March 31, 2014.

CMS also proposes to make the existing informal review process applicable to individual EPs who attempt to satisfactorily participate in a qualified clinical data registry.

Plan for the PQRS for the 2017 PQRS Payment Adjustment and Beyond (p. 463)

Although it is still operationally infeasible to establish a 12-month reporting period occurring any later than 2 years prior to the adjustment year for reporting via claims, CMS is seeking comment on this issue again due to ongoing requests that CMS establish reporting periods occurring closer to the year in which the payment adjustment is applied. For future years, should CMS consider a reporting period that occurs closer to the adjustment year for certain PQRS reporting mechanisms, such as the registry, EHR, and GPRO web interface reporting mechanisms? Should the reporting periods still be structured as 12-month reporting periods occurring in a calendar year or multiple years? What length of time should be used for the reporting period (e.g., shorter, quarterly reporting periods)?

Plan for the Future of the PQRS GPRO (p. 464)

Given public feedback that constant changes to the GPRO has caused confusion for GPRO participants, CMS did not propose many changes to the GPRO for the 2014 PQRS incentive or 2016 PQRS payment adjustment. However, it continues to receive feedback urging CMS to reconsider certain policies related to the GPRO, such as:

- **The definition of a PQRS group practice that limits the practice to a single TIN**, which poses operational challenges to groups that may operate as one healthcare entity but, due to business purposes, bill Medicare using multiple TINs. This definition has become increasingly problematic, particularly as some CMS programs with quality reporting components allow group practices containing multiple TINs to participate as a single group practice. CMS seeks comment on whether it should modify the current definition of group practice to account for multiple TINs (that is, change the identification unit(s) to recognize a group practice). And if so, what parameters should it put in place (e.g., if it allows multiple TINs to participate in PQRS as a single group practice, should it place geographical restrictions; should it require that these groups provide care for the same beneficiaries)?

- **Self-Nomination/Registration Process**. CMS seeks comment as to whether, in future years, it should move away from requiring group practices to self-nominate/register for the GPRO each year.
- **Satisfactory Reporting Criterion for Group Practices Using the GPRO web interface**. Currently, if the pool of assigned beneficiaries for a group using the GPRO web interface is less than 411 assigned beneficiaries for group practices with 100 or more EPs, then the group practice is required to report on 100% of assigned beneficiaries for both the PQRS incentive and payment adjustment. Therefore, a group with as few as one beneficiary assigned to the group could still qualify as long as the group successfully reports the measures included in the web interface for that one beneficiary. As data collected from the GPRO web interface starts getting used to calculate performance benchmarks for the VBM and/or Physician Compare, CMS questions whether performance results from group practices with few assigned beneficiaries could skew the benchmark calculations. It invites comments on whether it should establish minimum reporting thresholds for groups using the GPRO web interface and what the appropriate thresholds should be. Or, should CMS consider requiring group practices to be in existence prior to the start of the reporting period to use the GPRO web interface?

Future of Use of the Claims-based Reporting Mechanism in PQRS (p. 466)

The claims-based reporting mechanism is the most widely used PQRS reporting mechanism. However, it is also the reporting mechanism that allows for the most errors in reporting. Unlike claims-based reporting, registry and EHR users are at an advantage as they are able to analyze their quality data at the end of the year for any changes that may need to be made due to follow up care. It is also burdensome for CMS to analyze quality measures data from the claims-based reporting mechanism because it takes several months to analyze all claims for which reporting G-codes are submitted to CMS. For these reasons, CMS seeks comment on whether it should eliminate the claims-based reporting mechanism beginning with the reporting period (calendar year 2017) for the 2019 PQRS payment adjustment.

Future Submission Timelines for the Registry, EHR, GPRO Web Interface and Qualified Clinical Data Registry Reporting Mechanisms (p. 467)

CMS received feedback that the submission deadlines finalized in the FY 2013 final rule come too soon after the close of the reporting period. While it is not technically feasible to allow for submission of quality data via claims any later than the last Friday of the second month after the end of the respective reporting period (e.g., February 28, 2014 for the reporting period that ends December 31, 2013), CMS is exploring ways to collect data on a quarterly basis for quality measures submitted via registry, EHR, the GPRO web interface, as well as for the newly proposed qualified clinical data registry, rather than allowing for submission of quality measures data only once following a respective reporting period. CMS welcomes public feedback on these topics.

Integration of Clinical Quality Measures Reported Under the Hospital Inpatient Quality Reporting (IQR) Program (p. 468)

CMS has received feedback that the measures it has adopted under the PQRS do not adequately capture the practice of certain hospital-based physicians who bill Medicare Part B services and therefore are able to participate in PQRS. These physicians believe that measures, such as those available in the Hospital IQR Program, are more relevant to the care they provide. Therefore, it proposes to include the following measures available under the Hospital IQR Program that have been retooled for PQRS reporting via registry for purposes of the 2014 PQRS incentive and 2016 payment adjustment:

- **PN-6: Initial Antibiotic Selection for CAP in Immunocompetent Patient (CMS)**
- **VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis (Joint Commission)**
- **VTE-4: Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol (Joint Commission)**
- **ED-1a: Median Time from ED Arrival to ED Departure for Admitted ED Patients - Overall Rate (CMS)**

- **ED-1d: Median Time from ED Arrival to ED Departure for Admitted Patients - Psychiatric/Mental Health Patients (CMS)**
- **IMM-1c: Pneumococcal Immunization (PPV23) – High Risk Populations (Age 5 through 64 years) (CMS)**
- **HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems Survey (AHRQ)**

CMS seeks comment on whether additional Hospital IQR measures should be retooled for use in the PQRS and on whether CMS should attribute the reporting periods and performance results from the hospital IQR program to individual EPs or group practices who elect to have their hospital's performance scores attributed to them.

Feedback Reports (p. 469)

For those reporting PQRS measures via claims, CMS currently provides detailed information on the EP's reporting performance through two feedback reports each year. CMS seeks public comment on potentially merging feedback reports provided to PQRS and VBM participants so that an EP would receive one, merged report showing reporting data for the PQRS and performance data for the VBM.

Electronic Health Record (EHR) Incentive Program (p. 469)

Clinical Quality Measure (CQM) Reporting Options

In the EHR Incentive Program Stage 2 Final Rule, CMS established CQM reporting options for the Medicare EHR Incentive Program for CY 2014 and beyond that include one individual reporting option that aligns with the PQRS's EHR reporting option and two group reporting options that align with the PQRS GPRO and Medicare Shared Savings Program and Pioneer ACOs. In this proposed rule, CMS proposes two additional aligned options for EPs to report CQMs for the Medicare EHR Incentive Program for CY 2014 and beyond:

1) **Proposed Qualified Clinical Data Registry Reporting Option**: CMS proposes to allow, beginning with the 2014 reporting period, EPs to submit CQM information using qualified clinical data registries, according to the proposed definition and requirements outlined earlier in this rule for the PQRS. CMS proposes the following additional criteria for an EP who seeks to report CQMs for the Medicare EHR Incentive Program using a qualified clinical data registry:
   - EP must use CEHRT as required under the Medicare EHR Incentive Program. EP must have CEHRT that is certified to all of the certification criteria required for CQMs, including certification of the qualified clinical data registry itself for the functions it will fulfill (e.g., calculation, electronic submission). The registry also must be a certified EHR Module that is part of the EP's CEHRT
   - CQMs reported must be included in the Stage 2 final rule and use the same e-specifications established for the EHR Incentive Program
   - Report 9 CQMs covering at least 3 domains
   - If an EP's CEHRT does not contain patient data for at least 9 CQMs covering at least 3 domains, then the EP must report the CQMs for which there is patient data and report the remaining CQMs as "zero denominators" as displayed by the EP's CEHRT

   CMS proposes this qualified registry reporting option only for those EPs who are beyond their first year of demonstrating meaningful use. CMS notes, however, that this may not satisfy requirements for other quality reporting programs that have established 12-month reporting periods, such as the PQRS. Furthermore, the reporting periods established in the EHR Incentive Program Stage 2 final rule would continue to apply to EPs who would choose to report CQMs under this proposed qualified clinical data registry reporting option for purposes of the Medicare EHR Incentive Program. CMS intends to revisit the certification criteria with ONC in the Stage 3 rulemaking for the purpose of developing a more

flexible clinical data registry reporting option and certification criteria for the EHR Incentive Program, but welcomes public comments in the interim.

2) **Proposed Group Reporting Option – Comprehensive Primary Care (CPC) Initiative**: CMS proposes to add a group reporting option for CQMs for the Medicare EHR Incentive Program beginning in 2014 for EPs who are part of a CPC practice site that successfully submits at least 9 e-specified CQMs covering 3 domains. Each of the EPs in the CPC practice site would satisfy the CQM reporting component of meaningful use if the CPC practice site successfully submits and meets the reporting requirements of the CPC Initiative. Only EPs who are beyond their first year of demonstrating meaningful use may use this proposed CPC group reporting option. The CPC is a multi-payer initiative under which CMS pays participating primary care practices a care management fee to support enhanced, coordinated services.

Reporting of e-Specified CQMs for the Medicare EHR Incentive Program (p. 476)

CMS proposes that EPs who seek to report CQMs electronically under the Medicare EHR Incentive Program must use the most recent version of the e-specifications for the CQMs and have CEHRT that is tested and certified to the most recent version of the e-specifications for the CQMs. For example, for the reporting periods in 2014, EPs who want to report CQM data electronically for purposes of satisfying the quality measure reporting component of meaningful use would be required to use the June 2013 version of the CQMs e-specifications (available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html) and ensure that their CEHRT has been tested and certified to the June 2013 version of the CQMs. EPs who do not wish to report CQMs electronically using the most recent version of the e-specifications (e.g., if their CEHRT has not been certified for that particular version) would be allowed to report CQM data to CMS by attestation.

Medicare Shared Savings Program (pg. 479)

There are currently 33 quality performance measures under the Shared Savings Program. For ACOs beginning their agreement period in April or July, 2012, there will be 2 reporting periods in the first performance year, corresponding to calendar years 2012 and 2013. For ACOs beginning their agreement periods in 2013 or later, both the performance year and reporting period will correspond to the calendar year. Reporting on measures associated with a reporting period will generally be done in the spring of the following calendar year.

Medicare Shared Savings Program and PQRS Payment Adjustment (p. 479)

Through previous rulemaking, CMS incorporated certain PQRS reporting requirements and incentive payments into the Shared Savings Program, including 22 GPRO quality measures; reporting via the GPRO web interface; criteria for satisfactory reporting; and the January 1 through December 31 reporting period. CMS also determined that ACOs must report one ACO GPRO measure in 2013 to avoid the 2015 PQRS payment adjustment. Furthermore, EPs within an ACO may only participate under their ACO participant TIN as a group practice under the PQRS GPRO for purposes of avoiding the payment adjustment in 2015 (i.e., they may not seek to avoid the adjustment by reporting either as an individual under the traditional PQRS or under the traditional PQRS GPRO under their ACO participant TIN).

CMS proposes to align with the requirements for reporting under the traditional PQRS GPRO through the CMS web interface by requiring that ACOs satisfactorily report the 22 ACO GPRO measures during the 2014 and subsequent reporting periods to avoid the downward PQRS payment adjustment for 2016 and subsequent

years. CMS also proposes to continue the current requirement that ACO providers may only participate under their ACO participant TIN for purposes of the payment adjustment in 2016 and subsequent years.

Establishing the Quality Performance Benchmark (p. 483)

Through previous rulemaking, CMS established that:

- During the first performance year for an ACO, the quality performance standard would be set at the level of complete and accurate reporting
- During subsequent performance years, the quality performance standard would be phased in so that ACOs will be assessed on their performance on each measure
- CMS would designate a performance benchmark and minimum attainment level for each measure, and establish a point scale for the measures
- Performance benchmarks would be defined by CMS based on national Medicare FFS rates, national Medicare Advantage quality measure rates, or a national flat percentage, as required under statute
- CMS would not compare an ACO's quality performance to the performance of other ACOs for purposes of determining an ACO's overall quality score
- In future years, it would seek to incorporate actual ACO performance on quality measures into the quality benchmarks after seeking industry input through rulemaking

Data Sources Used to Establish Performance Benchmarks (p. 480). CMS proposes that for the 2014 reporting period, CMS would use all available and applicable national Medicare Advantage and Medicare FFS performance data to set the quality performance benchmarks. Specifically, in addition to using national Medicare FFS rates, which include data reported through PQRS, and national MA quality measure rates, it proposes to use data submitted by Shared Savings Program and Pioneer ACOs in 2013 for the 2012 reporting period to set the performance benchmarks for the 2014 reporting period. CMS proposes to publish the quality benchmarks based on these data prior to the beginning of the 2014 reporting period through sub-regulatory guidance. CMS will establish benchmarks using the most currently available data source and the most recent available year of benchmark data prior to the start of the reporting period. CMS proposes to retain the option of using flat percentages when data are unavailable, inadequate or unreliable to set quality performance benchmarks. CMS seeks comment on whether there are other data sources that should be considered in setting performance benchmarks.

Ensuring Meaningful Differences in Performance Rates (p. 485)

CMS seeks comment on whether a methodology should be applied to spread out clustered performance on measures (i.e., cases where slight differences in performance rates result in significant differences in the number of quality points obtained for the Shared Savings Program). It also seeks comment on a proposal to define clustered performance on a measure as a spread of performance rates between the 30th and 90th percentiles that is less than 6.0 percentage points, or whether other values should be used (e.g., minimum and maximum reported values are spread by less than 10.0 percentage points). CMS also welcomes feedback on whether there are alternative methodologies that should be considered to spread out clustered performance on measures. Finally, it seeks feedback on whether all available relevant data should be considered when developing the spread between measures, or whether only the relevant performance data from a subset of reporters, such as ACO-reported data should be used to determine the appropriate spread between deciles.

Scoring CAHPS Measures within the Patient Experience of Care Domain (p. 490)

In an effort to place a greater emphasis on patient-reported outcomes and experiences, CMS proposes to increase the point scoring for the Patient/Caregiver Experience domain so that it would be worth a total of 14

points, rather than 4 points, and so that each of the 7 measure modules in the domain would have equal weight. This change would bring the total points for the domain in line with the points available in other domains. However, this change would not affect the weighting of the domain itself in relationship to the other three domains; it would remain 25% of the ACO's total quality performance score.

Value-Based Payment Modifier and Physician Feedback Program (pg. 494)

In this rule, CMS continues to phase in implementation of the VBM by applying it to small groups of physicians and by increasing the amount of payment at risk. It also proposes to refine the methodologies used to calculate the modifier in order to better identify both high and low performers for upward and downward payment adjustments. Proposals include:

- To apply the VBM to groups of physicians with 10 or more EPs in 2016. CMS estimates that this proposal would result in about 17,000 groups (TINs) and nearly 60% of physicians to be affected by the VBM in 2016 (versus 25% if applicable only to groups of 100 or more). This decision is based on high levels of reliability associated with PQRS quality measures and the cost measures reported on in the 2010 and 2011 groups and individual Quality and Resource Use Reports (QRURs, see discussion below).CMS will identify groups using the same procedures as previously finalized, but rather than querying Medicare's PECOS database as of October 15, CMS proposes to perform the query within 10 days of the close of the PQRS group self-nomination/registration process.
- To accommodate the various ways in which physicians can participate in the PQRS and foster alignment between programs, CMS proposes for the 2016 VBM that Category 1 would include groups of physicians that satisfy PQRS reporting via the GPRO (through use of the web-interface, EHRs, or qualified registry reporting mechanisms) for the 2016 PQRS payment adjustment (as listed in Table 27).
- Recognizing that not all groups of physicians may want to participate in PQRS as a group under the GPRO and may prefer to have all of their EPs continue to report PQRS measures as individuals that best reflect their clinical practice, CMS also proposes that a group of physicians subject to the 2016 VBM would fall under Category 1 if at least 70% of the individual EPs in the group avoid the 2016 PQRS payment adjustment by any of the reporting options available under the PQRS. CMS selected this threshold in order to recognize that many individuals may be reporting PQRS data for the first time in 2015 and in order to avoid imposing too high of a burden on these groups that does not increase the reliability of the group's quality.
- To make quality-tiering mandatory for groups within Category 1 for the 2016 VBM; groups with between 10 and 99 EPs would be subject only to any upward or neutral adjustment, while groups with 100 or more EPs would be subject to upward, neutral, or downward adjustments.
- To increase the downward adjustment from 1.0% in CY 2015 to 2.0% for CY 2016 for groups that fall in Category 2 and do not satisfy PQRS.
- To increase the maximum amount of payment at risk under the VBM quality-tiering strategy from 1.0% to 2.0% in 2016. It would be 2.0% for groups of physicians classified as low quality/high cost and -1.0% for groups classified as either low quality/average cost or average quality/high cost.
- To align the quality measures and quality reporting mechanisms for the VBM with those available to groups of physicians under the PQRS during the 2014 performance period.
- To include the Medicare Spending Per Beneficiary (MSPB) measure in the total per capita costs for all attributed beneficiaries domain of the cost composite.
- To refine the cost measure benchmarking methodology to account for the specialties of the physicians in the group.

TABLE 62: Proposed 2016 Value-Based Payment Modifier Amounts (p. 514)

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

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

The upward payment adjustment factor ("x") would be determined after the performance period has ended based on the aggregate amount of downward payment adjustments.

VBM Performance Periods (p. 514)

Although CMS acknowledges concerns about the gap between the end of the performance period (e.g., December 31, 2014) and the beginning of the payment adjustment period (e.g., January 1, 2016), it proposes to use CY 2015 as the performance period for the VBM adjustments that will apply during CY 2017. CMS notes that any strategies to close this gap would have to alter the performance period rather than the payment adjustment period since the latter is tied to the PFS and updated on an annual calendar year basis. One option could be to adjust the performance period for quality data reported through the PQRS or to calculate the total per capita cost measures on an April 1 through March 31 basis. However, the period during which groups of physicians would be able to review the calculation of the VBM would have to be shortened. CMS will continue to work to reduce this gap and seeks public comments on the merits of different strategies, noting that there will always be some gap to account for various operational processes, such as allowing for a three-month claim run out so that physicians are evaluated on complete and accurate information.

Quality Measures (p. 517)

For the 2016 VBM, CMS proposes to include all of the PQRS GPRO reporting mechanisms available to group practices for 2014 and all of the PQRS reporting mechanisms available to individual EPs for 2014. This includes a 6-month reporting period for individual reporting via registry, which CMS believes would produce sufficiently reliable data on which to evaluate quality for purposes of the VBM since it requires data on at least 20 beneficiaries.

CMS also proposes to use all quality measures available for reporting under these various PQRS reporting mechanisms, including quality measures reported through qualified clinical data registries, to calculate the VBM in 2016 to the extent that a group submits data on these measures. Groups with 25 or more EPs also can elect to have PQRS CAHPS survey data, collected in 2014, included in their VBM for CY 2016 (see Tables 24 through 27). The 3 outcome measures finalized last year-- the two composites of rates of potentially preventable hospital admissions and the all-cause hospital readmission measure – would continue to be included in the quality measures used for the VBM in 2016. CMS believes it is premature to require reporting on a core set of measures, despite some public support, and prefers to provide physicians with the flexibility to choose the data it reports for quality measures.

For groups subject to the VBM in 2016 whose EPs participate in the PQRS as individuals rather than as a group practice under the GRPO (i.e., groups of physicians that are assessed under the 70% threshold), CMS proposes to calculate the group's performance rate by combining the weighted average of the performance rates for each measure reported by at least one EP in the group. If all of the EPs in a group participate in a PQRS qualified

clinical data registry in 2014 and CMS is unable to receive quality performance data for those EPs for the reasons discussed above, for purposes of the VBM, CMS proposes to classify the group's quality composite score as "average" under the quality-tiering methodology, because it would not have data to reliably indicate whether the group should be classified as high or low quality.

Inclusion of the Medicare Spending per Beneficiary Measure in the VBM Cost Composite (p. 551)

CMS previously finalized to include the following five cost measures in the VBM cost composite:

- Total per capita costs for all attributed beneficiaries (both Parts A and B)
- Total per capita costs for beneficiaries with four specific chronic conditions: chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes

In this rule, CMS proposes to add the Medicare Spending per Beneficiary (MSPB) measure to the Total Per Capita Costs for All Attributed Beneficiaries domain for the VBM (the 2 measures in this domain would be weighted equally) for 2016. The MSPB measure is currently included in the Hospital IQR Program and the Hospital VBM Program. It evaluates all costs incurred by a beneficiary related to the totality of services furnished surrounding an inpatient hospitalization. The measure includes all Medicare Part A and Part B payments during an MSPB episode, which spans from 3 days prior to an index admission through 30 days post discharge with certain exclusions. For example, admissions that result in a transfer from one acute hospital to another, episodes that occur fewer than 30 days before the end of the performance period, or episodes during which the beneficiary is not enrolled in both Part A and Part B Medicare do not count as index admissions. Costs for each episode are risk-adjusted for age and severity of illness, and the included payments are standardized to remove differences attributable to geographic payment adjustments and other payment factors. Additional information on the measure, including a detailed specification document (entitled "MSPB Measure Information Form") and the payment standardization methodology (entitled "CMS Price Standardization") can be found in the "Measure Methodology" section at:
http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772053996

Unlike the Hospital IQR and VBP Programs, in which CMS attributes the MSPB index admission to the hospital at which the index admission occurred, CMS proposes to attribute an MSPB episode to a group of physicians subject to the VBM (as identified by a single TIN), when any eligible professional in the group submits a Part B Medicare claim under the group's TIN for a service rendered during an inpatient hospitalization that is an index admission for the MSPB measure. Thus, the same index admission and MSPB episode could be attributed to more than one group of physicians. Based on CY 2011 claims data, the proposed approach would enable approximately 11,419 groups of physicians with at least 10 EPs to have an MSPB measure score included in their cost composite.

CMS also is considering an attributing the MSPB episode to physician groups from which an EP in the group billed a part B claim for a service rendered at *any time during the MSPB episode* (i.e., from 3 days prior to an index admission through 30 days post-discharge). This attribution approach would place an even stronger emphasis on shared accountability for care provided to Medicare beneficiaries who are hospitalized, both during and after their hospitalization. CMS estimates that this attribution method would enable an additional 3,017 groups of physicians with 10 or more EPs, or over 14,000 total, to receive an MSPB measure performance rate for inclusion in the cost composite, as compared to its proposed approach, which considers only those EPs who bill a Part B claim *during* the hospitalization.

CMS also considered other methods, such as attributing an MSPB episode to the group of physicians that provided the plurality of Part B services billed either during the entire MSPB episode (i.e., 3 days prior to hospital admission through 30 days post discharge) or during the index hospitalization only. CMS seeks comment on these alternative approaches, under which fewer groups would be eligible to receive an MSPB measure rate. CMS considered these alternative methods because they identify groups that were "most responsible" for the Part B Medicare payments made during the episode. However, it does not propose to use these methods because it believes the multiple attribution approach better incentivizes a team approach to care and will affect more TINs.

CMS proposes 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 VBM cost composite, which it believes will produce reliable results. CMS also considered a minimum number of 10 episodes, which would enable CMS to calculate the MSPB measure for an additional 12,332 physician groups while still maintaining reliability. Groups for which CMS attributes fewer than 20 cases to calculate any cost measure would have their cost composite classified as "average" cost.

CMS also considered 2 methods to account for the group's specialty composition so that the quality-tiering methodology produces fair peer group comparisons and correctly ranks group of physicians based on actual performance. The first method, "specialty adjustment," accounts for the specialty composition of the group prior to computing the standardized score for each cost measure. This method includes 3 steps, which are discussed and illustrated on pgs. 535-537. Table 66 (p. 538) includes the percentage of physicians in each specialty that practice in groups with 20 or more attributed beneficiaries and that, based only on this one measure, would be classified into low, average, and high cost groups. The second method, "comparability peer grouping," constructs peer groups for each physician group practice by identifying group practices with the nearest comparable specialty mix. CMS would then calculate a benchmark for the peer group and use the benchmark to calculate the group's standardized score for that measure. Under this approach, two group practices would be considered to have the same specialty mix if the share of physicians of each specialty is within a defined range for both group practices. For the purposes of computing peer groups, group practices also could be stratified by size, as measured by number of EPs billing under the group practice's TIN. A group practice's peer group, however, would include a minimum number of peers (i.e., group practices with similar specialty mixes) to ensure a reliable comparison.

CMS prefers the "specialty adjustment" method since it allows CMS to apply the VBM to smaller size groups and solo practitioners, creates one national benchmark for each cost measure, and allows all groups of physicians (regardless of size) to be assessed against that benchmark in creating the group of physicians' standardized score. The other "comparability peer grouping" method would require CMS to define which groups of physicians are similar enough to be included in each group of physicians' peer group and would create a different benchmark for each group of physicians, which may make it more difficult for groups to understand how their costs are benchmarked. As such, CMS proposes the specialty benchmarking method to create the standardized score for each group's cost measures beginning with the 2016 VBM. CMS proposes to identify the specialty for each EP based on the specialty that is listed on the largest share of the EP's Part B claims. CMS recognizes that many physicians believe its current specialty designations may mask sub-specialist care furnished and points readers to the procedures for obtaining a CMS specialty code at:
http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Taxonomy.html

CMS supports the MSPB measure since it aligns with these other programs and addresses physician care associated with acute inpatient hospitalizations and post-acute care, the latter of which is a major source of unexplained variation in Medicare spending according to a recent IOM report.

Both the MSPB and the Total Per Capita Costs measure are still under NQF consideration. CMS notes that it continues to work through the NQF endorsement process, gaining valuable feedback on a variety of issues (e.g., attribution and risk adjustment), and will continue to refine cost measures through future rulemaking based on feedback received from NQF and others.

In future rulemaking, CMS intends to propose to replace the four measures in the Total Per Capita Costs for Beneficiaries with Specific Conditions domain with cost measures derived from the CMS Episode Grouper and other episode-based costs derived from CMS' recent and ongoing work with specialty societies. CMS solicits comments on these potential changes.

Physician Feedback Program (p. 543)

In 2012, CMS provided Quality and Resource Use Reports (QRURs) to 54 large group practices (200 or more) and to over 31,000 individual physicians in 9 states that practice in groups of physicians with 25 or more EPs. Each report provided information on 30 quality measures and 5 cost measures for Medicare FFS beneficiaries treated by the medical groups in CY 2011. In addition, in May 2013, CMS provided supplemental QRURs to the group report recipients that featured episode-based costs for care of pneumonia and several acute and chronic cardiac conditions. It derived these episode-based costs using the newly developed CMS Episode Grouper software.

After conducting statistical reliability analyses on the cost and quality measures contained in the 2010 and 2011 individual and group QRURs, which are the same measures that will be used for the VBM, CMS found that they were statistically reliable at a high level. More information about findings from these reports is available at http://www.cms.hhs.gov/physicianfeedbackprogram.html and http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ReportTemplate.html

Episode Costs and the Supplemental QRURs (p. 549). As required under the ACA, CMS has developed a prototype episode grouper that, for a limited number of conditions, classifies episodes into three categories: chronic, acute, and procedural. To illustrate how the CMS Episode Grouper works, in June 2013 it made Supplemental QRURs available to the 54 large group practices that received group QRURs in December 2012. They included the following five major episodes:

- **Pneumonia** (acute condition) (with/without inpatient hospital stay)
- **AMI** (acute condition) (with/without PCI or CABG)
- **CAD** (chronic condition) (with/without AMI)
- **CABG** (procedural) (without AMI)
- **PCI** (procedural) (without AMI)

Episode assignment to medical practice groups for the Supplemental QRURs was based on one or more of the following three methods, depending upon the episode type:

- Performance of specific procedures
- Plurality (35%) of episode EP fee schedule (PFS) costs billed
- Plurality or shared majority (35%) of E&M visits

To control for patient case-mix, the CMS Episode Grouper applied a risk adjustment methodology that calculated each episode's expected cost based on three factors: patient health status; demographics; and beneficiary type. It then calculated the predicted cost of an episode using information available at the start of the episode. The use of such a prospective risk model avoids allowing providers to influence their risk-adjusted costs by changing their treatment patterns during the episode. To make the Supplemental QRURs more actionable for medical groups, CMS also identified a "Suggested Lead Eligible Professional" of the episode who is likely to be directing the care. More information about the Supplemental QRURs is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Episode-Costs-and-Medicare-Episode-Grouper.html

These Supplemental QRURs are the beginning of an extended process of incorporating episode costs into the QRURs. CMS intends to develop the CMS Episode Grouper and to broaden the number of conditions that could be addressed by episode grouping. CMS acknowledges its work with several specialty societies representing physicians in cardiology, emergency medicine and other specialties to develop episode costs or other cost or utilization metrics to include in the annual QRURs. CMS also notes that the feedback it expects from the recipients of the 2011 reports will inform next steps.

Future Plans for the Physician Feedback Reports (p. 552). In September, 2013, CMS plans to provide the QRURs at the TIN level to all groups of physicians with 25 or more EPs based on CY 2012 performance data. CMS anticipates that there will be approximately 6,750 reports covering approximately 440,000 physicians. These reports will include a "first look" at the VBM methodologies using the group's PQRS measures, outcome measures, and cost measures.

The reports also incorporate many valuable suggestions received from specialty societies on ways to improve the reports, including:

- Beneficiaries attributed to the group practice
- EPs billing under the group's TIN; and
- Hospitalizations for attributed beneficiaries to help each group manage its patients and potentially reduce hospital admissions

In the late summer of 2014, CMS will disseminate the QRURs based on CY 2013 data to all physicians (i.e., TINs of any size) even though groups of physicians with fewer than 100 EPs will not be subject to the VBM in CY 2015. These reports will contain performance on the quality and cost measures used to score the composites and additional information to help physicians coordinate care and improve the quality of care furnished.

CMS continues to look at ways to streamline the QRURs in order to create one unified format for quality assessment across federal programs and to increase their utility in future years.

Appendix A. Proposed Requirements for Qualified Clinical Data Registries

- Able to submit quality measures data to CMS for purposes of demonstrating that, for a reporting period, its eligible professionals have satisfactorily participated in PQRS
- Have in place mechanisms for the transparency of data elements and specifications, risk models, and measures
- Submit quality measure data on multiple payers, not just Medicare patients
- Provide timely physician feedback at least quarterly
- Possess a method for benchmarking that allows for comparisons among EPs performing the same or similar functions. CMS notes that national benchmarking is preferred, but sets benchmarking across EPs as the minimum standard.
- Exist as of January 1 the year prior to the year for which the entity seeks to become a qualified clinical data registry (e.g., January 1, 2013, to be eligible to participate for purposes of data collected in 2014)
- Have at least 100 registry participants by January 1 the year prior to the year for which the entity seeks to submit clinical quality measures data. Not all participants would be required to participate in PQRS. Since CMS believes these registries should be more robust in technical capabilities than a traditional PQRS-qualified registry (i.e., those that report PQRS measures to CMS), it would maintain the requirement that a traditional PQRS-qualified registry have at least 25 registry participants.
- Not owned or managed by an individual, locally-owned, single-specialty group (e.g., single-specialty practices with only 1 practice location or solo practitioner practices)
- Enter into and maintain with participating professionals a Business Associate agreement that provides for the registry's receipt of patient-specific data from the EPs and the registry's public disclosure of quality measure results
- Describe to CMS the cost charged to EPs to submit data to CMS
- Describe its plan to maintain Data Privacy and Security for data transmission, storage and reporting
- Comply with a CMS-specified secure method for quality data submission
- Provide information on each measure to be reported by an EP, including a summary of supporting evidence/rationale, title, numerator, denominator, exclusions/exceptions, data elements and value sets, in addition to measure level reporting rates, patient-level demographic data and/or the data elements needed to calculate the reporting rates by TIN/NPI
- Submit an acceptable "validation strategy" to CMS by March 31 of the reporting year the entity seeks qualification. This would detail how the registry will determine whether EPs succeed in reporting quality measures. Acceptable strategies include the capability to conduct random sampling of participant's data or other credible means of verifying the accuracy of data, completeness of reporting, or adherence to a required sampling method. For a template for data validation and integrity, CMS urges the public to view the requirements for federal certification of an EHR product, available at: http://www.healthit.gov/policy-researchers-implementers/2014-edition-final-test-method
- Perform the validation outlined in the strategy and send evidence of successful results to CMS by June 30 of the year following the reporting period (e.g., June 30, 2015, for data collected in the reporting periods occurring in 2014)
- Obtain and keep on file for at least 7 years signed documentation that each holder of an NPI whose data are submitted to the qualified clinical data registry has authorized the registry to submit quality measure results and numerator and denominator data and/or patient-specific data on beneficiaries to CMS for the purpose of PQRS participation. This documentation would be required to be obtained at the time the EP signs up with the registry
- Upon request, provide CMS access to the registry's database to review the beneficiary data on which the qualified clinical data submissions are based or provide to CMS a copy of the actual data
- Make available to CMS samples of patient level data to audit the entity for purposes of validating the data submitted to CMS, if determined to be necessary
- Prior to CMS posting the list of qualified clinical data registries for a particular year, verify the information contained on the list (e.g., names, contact information, measures, cost, etc.) and agree to furnish/support all of the services listed
- Provide information on how the entity collects quality measurement data, if requested
- By March 31 of the year in which the entity seeks to participate in PQRS as a qualified clinical data registry, the entity must publically post (on the entity's website or other publication available to the public) a detailed description (rationale, numerator, denominator, exclusions/exceptions, data elements) of the quality measures it collects to ensure transparency of information to the public
- Demonstrate that it has a plan to publicly report quality data about individual professionals, as well as view regional and national benchmarks. As an alternative, CMS considered requiring that the registry benchmark within its own registry for purposes of determining relative quality performance where appropriate.
- Demonstrate that it has a plan to risk adjust the quality measures data that it collects and intends to transmit to CMS, where appropriate
- Able to transmit quality measure data to CMS, upon request, either via a CMS-approved XML format or via the Quality Reporting Document Architecture (QRDA) category III format. The XML format is consistent with how traditional PQRS qualified registries transmit data on quality measures to CMS. In future years, CMS intends to require all qualified clinical data registries

to submit measures data via the QRDA category III format since this is one of the formats it requires for EHR data submission of quality measures data.

- Report back to participants on the completeness, integrity, and accuracy of its participants' data.