The Issue:
The Centers for Medicare & Medicaid Services (CMS) published the Medicare physician fee schedule (PFS) proposed rule for calendar year (CY) 2014 in the July 19 Federal Register. Comments are due to CMS by Sept. 6. Changes in the rule are generally effective Jan. 1. In addition to updating payment weights and rates, the rule would:

- Fully subject critical access hospitals (CAHs) to the cap on outpatient therapy services, beginning Jan. 1;
- Allow payment for telehealth services originating in certain rural areas of Metropolitan Statistical Areas, in an attempt to ameliorate the impact of nearly 100 counties being re-designated from rural to urban based on 2010 census data;
- Explicitly pay qualifying physicians and non-physician practitioners (NPPs) for complex chronic care management services;
- Reduce the group practice size eligible for the value-based payment modifier (VBM) from 100 eligible professionals (EPs) to 10 EPs for CY 2016, which would result in approximately 58 percent of physicians being included in the VBM for CY 2016; and
- Limit payment for certain services delivered in a physician office to the total payment received when the same service is delivered in a hospital outpatient department or ambulatory surgical center.

Without congressional action, CMS estimates that Medicare payments to physicians and qualifying NPPs will decline by a mandated 24.4 percent on Jan. 1 due to the flawed sustainable growth rate formula.

Our Take:
The AHA supports the agency’s proposal to expand telehealth services to rural areas located within MSAs and to pay physicians for complex chronic care management services. We strongly oppose full application of the therapy cap to CAHs. In addition, the AHA will continue to urge Congress to fix the flawed physician payment formula, and to do so in a manner that does not result in reduced payments to hospitals and other providers.

What You Can Do:
- Share this advisory with your chief medical officer, chief financial officer and other members of your senior management team; key physician leaders; and nurse managers.
- Assess the potential impact of the proposed payment changes on your Medicare revenue and operations.
- Consider submitting comments to CMS identifying your concerns about the proposed rule.

Further Questions:
Contact Melissa Jackson, senior associate director for policy, at (202) 626-2356 or mjackson@aha.org.
# Medicare Physician Fee Schedule
## Proposed Rule for CY 2014

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**BACKGROUND**

On July 8, the Centers for Medicare & Medicaid Services (CMS) released its proposed rule for calendar year (CY) 2014 with changes to the Medicare physician fee schedule (PFS) and other revisions under Medicare Part B. The proposed rule was published in the July 19 Federal Register. Comments are due to CMS by Sept. 6. A final rule will be issued by Nov. 1, and changes proposed in the rule generally would be effective Jan. 1.

**AT ISSUE**

**Conversion Factor**

*The American Taxpayer Relief Act of 2012 (ATRA)* halted significant Medicare physician payment cuts projected for CY 2013 by extending physician payments at current levels through Dec. 31. Without additional congressional action, however, CMS estimates that physician payments will decline by a mandated 24.4 percent on Jan. 1. **Cuts of this magnitude are unreasonable.** The AHA continues to urge Congress to fix the flawed physician payment formula, and to do so in a manner that does not result in reduced payments to hospitals and other providers.

**Site-neutral Payment for Certain Physician Services**

*The Patient Protection and Affordable Care Act (ACA)* requires CMS to periodically identify potentially misvalued services and appropriately adjust the relative values for those services. As part of this initiative, CMS has identified certain services for which Medicare’s payment when the service is furnished in the physician office exceeds the total Medicare payment when the service is furnished in a hospital outpatient department (HOPD) or an ambulatory surgical center (ASC). In contrast, CMS states that hospitals and ASCs typically incur higher overhead costs in delivering services than are incurred in a physician office. CMS states that this is due to hospitals maintaining the capability to furnish services around the clock and treating higher acuity patients than those seen in a physician office, in addition to the costs of compliance with legal obligations such as the *Emergency Medical Treatment and Labor Act* (EMTALA). Further, hospitals and ASCs must meet Medicare conditions of participation and conditions for coverage.

CMS believes the discrepancy is due to a number of factors, including the data which are used to calculate Practice Expense (PE) Relative Value Units (RVUs), which reflect the costs of employing staff, obtaining office space and buying supplies and equipment. The methodology relies on voluntary submission of information by physicians who furnish the services and are paid in part based on the data they provide. In addition, information has been difficult to obtain on certain direct costs, such as the cost of high-priced disposable supplies and capital equipment. Finally, data used in the PE methodology are often outdated. In contrast, Medicare outpatient prospective payment system (OPPS) payment rates are based on auditable hospital cost data and are updated annually.
CMS proposes to address this discrepancy by limiting payment for nearly 200 identified services when provided in a physician office to the total payment made when the service is delivered in a HOPD or an ASC. Specifically, CMS proposes to limit the non-facility PE RVU when it results in a higher payment than the sum of the facility PE RVU plus the corresponding facility fee under the OPPS or ASC (note that if a service is on the ASC list, the ASC rate will be used for comparison purposes). The following services would be exempted from this policy:

- Services without separate OPPS payment rates;
- Codes subject to the Deficit Reduction Act of 2005 (DRA) imaging cap;
- Codes with low volume in the OPPS or ASC (5 percent or less of the total number of services are furnished in the OPPS setting relative to the total number of PFS/OPPS allowed services);
- Codes with ASC rates based on PFS payment rates;
- Codes paid in the facility at non-facility PFS rates; and
- Codes with PE RVUs developed outside the PE methodology.

In its impact statement, CMS estimates the effect of this proposal on total allowed charges by specialty. Most specialties would experience a limited impact, seeing increases or decreases of 1 percent or less. However, the following specialties would see a decrease of 5 percent or more: interventional radiology (6 percent); pathology (8 percent); radiation oncology (6 percent); rheumatology (5 percent); diagnostic testing facilities (7 percent); independent laboratories (27 percent); and radiation therapy centers (13 percent).

**Multiple Procedure Payment Reduction (MPPR)**

CMS is not proposing any changes to the MPPR policy. However, the agency will continue to consider expanding the MPPR in future rulemaking.

**Proposed Data Collection on Off-campus Provider-based Departments**

In the proposed rule, CMS discusses collecting information that would help it better understand the treatment of off-campus provider-based outpatient departments. Specifically, the agency is interested in collecting data that would allow it to analyze the frequency, type and payment for services furnished in off-campus provider-based hospital departments. CMS states that it is interested in this area because of the growing trend in hospital acquisition of physician practices, in addition to the Medicare Payment Advisory Commission’s site-neutral proposal to pay selected hospital outpatient services at PFS rates. CMS is considering the following data collection methods:

- Creating a new place of service code for off-campus departments of a provider as part of the CMS-1500 claim form;
- Creating a HCPCS modifier that could be reported with every code for services furnished in an off-campus provider-based department of a hospital on the CMS-1500 claim form; and
• Asking hospitals to break out the costs and charges for their provider-based departments as outpatient service cost centers on the Medicare hospital cost report.

CMS requests comment on the best means for collecting information on the frequency, type, and payment for services furnished in off-campus provider-based departments of hospitals.

**Medicare Economic Index (MEI)**

CMS proposes to revise the MEI for CY 2014. Specifically, CMS seeks to reclassify and revise certain cost categories and to revise work and PE cost weights and certain price proxies. CMS estimates that the revised MEI for CY 2014 would yield an increase to PFS payment rates of 0.7 percent. This is 0.1 percentage point lower than the projected increase would be under the current MEI.

**Geographic Practice Cost Indices (GPCIs)**

Current law requires that CMS review and, if necessary, adjust the GPCIs at least every three years. CMS proposes to update the GPCIs for CY 2014 using more recent data. Statute requires that when more than one year has elapsed since CMS last updated the GPCIs, the next update must be phased in over two years by applying one half of the update in the first year and the remainder in year two. The last update was in CY 2012. Therefore, CMS has proposed GPCIs for CY 2014 and CY 2015 in Addendum E of the rule, available at the CMS [Physician Fee Schedule website](#).

In addition, by law, the current 1.0 work GPCI floor will expire on Dec. 31. The 1.5 work GPCI floor for Alaska and the 1.0 practice expense GPCI floor for the frontier states (defined as Montana, Nevada, North Dakota, South Dakota and Wyoming) are permanent and, thus, applicable for CY 2014.

**Medicare Telehealth**

Under current law, Medicare beneficiaries are eligible for telehealth services only when those services are provided from an originating site located outside of a Metropolitan Statistical Area (MSA) or in a rural Health Professional Shortage Area (HPSA). Earlier this year, the Office of Management and Budget updated the MSAs based on the 2010 census data. As a result, the designation of nearly 100 counties changed from rural to urban. Therefore, Medicare beneficiaries who receive care in these newly urban counties are no longer eligible for telehealth services. The AHA has urged CMS to restore access to telehealth services in those counties.

CMS proposes to allow rural census tracts located in MSAs to be considered rural in accordance with a methodology used by the Office of Rural Health Policy (ORHP). The effect of this change is that some rural areas within MSAs will gain access to Medicare telehealth services. CMS states that it believes this change in policy will expand access to telehealth services, though it is not yet clear how the change will affect the 100 counties that lost their rural health designation.
In addition, CMS proposes to establish and maintain geographic eligibility for an originating telehealth site on an annual basis. Specifically, eligibility would be based on the status of the area as of Dec. 31 of the prior calendar year. This proposal would reduce the likelihood that a mid-year change by an entity other than CMS would disrupt Medicare beneficiaries’ access to telehealth services.

Finally, CMS proposes to add transitional care management services (CPT codes 99495 and 99496) to its list of approved Medicare telehealth services. These services were created in the CY 2013 PFS final regulation.

**Therapy Services**

The ATRA extended a number of temporary changes to Medicare outpatient therapy – physical therapy, occupational therapy and speech-language pathology services. Specifically, the law extended through Dec. 31 the current therapy cap exceptions process; the temporary application of the therapy cap to therapy services provided in HOPDs; and a manual medical review process for therapy cap exceptions that reach a threshold of $3,700 per year. It also required CMS to count therapy services furnished by a critical access hospital (CAH) toward the therapy cap using the amount that would be paid for the service under the PFS. However, the ATRA did not apply the therapy cap to services furnished by a CAH – meaning that a CAH could provide therapy services above the cap without following the therapy cap exceptions process.

As a result of the ATRA, CMS reassessed and now proposes to reverse its longstanding interpretation of existing statute by subjecting CAHs to the therapy cap beginning Jan. 1. In doing so, CMS differentiates CAHs from HOPDs, so that CAHs would be subject to the cap on Jan. 1 even though, under current law, HOPDs will no longer be subject to the cap on that date. Further, unless Congress acts, the exceptions process will end on Jan. 1, and claims CAHs submit for services above the cap will be denied. The AHA opposes application of the therapy caps to CAHs and will urge CMS not to finalize this flawed policy. In addition, we support an extension of the therapy cap exceptions process for CY 2014 and beyond, but we urge Congress to do so without expanding the cap to therapy services provided in hospital outpatient settings.

**Requirements for Billing “Incident To” Services**

CMS proposes to revise current regulations to require as a condition of payment that an individual who provides services and supplies “incident to” a physician’s professional services must meet any applicable state requirements, including licensure, and that services and supplies must be provided in accordance with state law. In the rule, CMS notes that physicians and other practitioners authorized to bill Medicare must comply with state law; however, there is no similar requirement for auxiliary personnel who provide “incident to” services.
Complex Chronic Care Management Services

CMS proposes to establish a separate payment under the PFS, beginning in CY 2015, for complex chronic care management services provided to patients with multiple complex chronic conditions. CMS defines complex chronic conditions as conditions that are expected to last at least 12 months or until the death of the patient and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

CMS proposes to create two new G-codes to describe chronic care management services:

- GXXX1: initial services; one or more hours; initial 90 days, and
- GXXX2: subsequent services; one or more hours; subsequent 90 days.

CMS states that it would consider the scope of complex chronic care management services to include the following:

- The provision of 24-hours-a-day, 7-days-a-week access to address a patient’s acute complex chronic care needs. The patient would need to have a way to contact the provider at any time to address complex chronic care needs, and members of the care team involved in after-hours care of a patient would be expected to have access to the patient’s full electronic health record (EHR);
- Continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments;
- Care management for chronic conditions, including systematic assessment of a patient’s medical, functional and psychosocial needs, and creation of a patient-centered plan of care that meets certain criteria;
- Management of care transitions, with the practice expected to be able to facilitate communication of relevant patient information through electronic exchange of a summary care record;
- Coordination with home and community-based clinical service providers; and
- Enhanced opportunities for a patient to communicate with the provider by telephone as well as the use of secure messaging, Internet or other asynchronous non face-to-face consultation methods.

CMS also proposes a number of requirements that providers billing complex chronic care management services must meet, including:

- The provider must obtain informed consent for the services from the Medicare beneficiary, and must reaffirm consent at least every 12 months;
- Providers may bill for subsequent services (GXXX2) only when the medical needs of the patient require substantial revision of the care plan (typically when the patient’s clinical condition changes significantly);
- Providers may not bill transitional care management services (CPT 99495, 99496), home health care supervision (HCPCS G0181) and hospice care supervision (HCPCS G0182) separately during the 90 days for which either
GXXX1 or GXXX2 are billed. Similarly, end-stage renal disease (ESRD) services (CPT 90951-90970) cannot be billed separately during the same 90-day period;

- If a face-to-face visit is provided during the 90-day period, the provider may bill the appropriate evaluation and management (E/M) code;
- A provider must deliver at least 60 minutes of complex chronic care management services over the 90-day period in order to bill one of the two codes. Time less than 60 minutes cannot be rounded up; however, the provider may count time spent by clinical staff members; and
- In order for a provider to bill for these services, the beneficiary must have received an annual wellness visit within the past 12 months.

CMS invites comment on potential standards for complex chronic care management services, including use of EHRs that meet the most recent Health and Human Services (HHS) standard for meaningful use; employment of one or more advanced practice nurses or physician assistants whose job descriptions include provision of complex chronic care management; and access for all practitioners to the beneficiary’s EHR at time of services. CMS also invites comment on whether recognition as a medical home by a national organization that formally recognizes medical homes should be used to demonstrate that a provider has met the required standards to provide complex chronic care management services.

**Food & Drug Administration Investigational Device Exemption (IDE) Clinical Studies**

Medicare coverage for items and services that fall under the IDE is divided into two categories. Category A devices are considered experimental/investigational; Medicare coverage is available for the costs of routine items and services in Category A IDE studies and trials but not for the Category A device. In contrast, Category B devices are considered non-experimental/investigational and Medicare covers the costs of routine items and services plus the Category B device in IDE studies and trials.

In the rule, CMS proposes to create 13 standards that Category A IDE studies would be required to meet in order for the costs of routine care items and services to be coverable by Medicare:

- The principal purpose of the study is to test whether the item or service meaningfully improves health outcomes of patients who are represented by the Medicare-enrolled subjects;
- The rationale for the study is well supported by available scientific and medical information, or it is intended to clarify or establish the health outcomes of interventions already in common use;
- The study results are not anticipated to unjustifiably duplicate existing knowledge;
- The study design is methodologically appropriate and the anticipated number of enrolled subjects is appropriate to answer the research question(s) being asked in the study;
- The study is sponsored by an organization or individual capable of completing it successfully;
• The study is in compliance with all applicable federal regulations concerning the protection of human subjects;
• All aspects of the study are conducted according to appropriate standards of scientific integrity set by the International Committee of Medical Journal Editors;
• The study has a written protocol that clearly demonstrates adherence to the standards listed as Medicare requirements;
• Where appropriate, the clinical research study is not designed to exclusively test toxicity or disease pathophysiology in healthy subjects (the only exceptions would be if the disease or condition being studied is life-threatening and the patient has no other viable treatment options, or the disease or condition is severely debilitating);
• The study is registered on the ClinicalTrials.gov website and/or the Registry of Patient Registries (RoPR) by the principal sponsor/investigator prior to the enrollment of the first study subject;
• The study protocol specifies the method and timing of public release of results on all pre-specified outcomes, including release of negative outcomes. The results must be made public within 24 months of the end of data collection;
• The study protocol explicitly discusses subpopulations affected by the item or service under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria affect enrollment of these populations, and a plan for the retention and reporting of said populations in the study; and
• The study protocol explicitly discusses how the results are or are not expected to be generalizable to subsections of the Medicare population to infer whether Medicare patients may benefit from the intervention.

In addition, CMS proposes two criteria for Category A studies that, if met, would lead to automatic Medicare coverage of routine items and services. First, the study is a pivotal study, defined as a clinical investigation designed to collect definitive evidence of the safety and effectiveness of a device for a specified intended use, typically in a statistically justified number of subjects. Second, the study has a superiority study design, defined as a study or trial that is intended to demonstrate at some pre-specified level of confidence that the effect of an investigational treatment is superior to that of an active control by more than a pre-specified margin.

CMS also proposes extending these standards and criteria to coverage of items and services in Category B IDE studies. Finally, CMS proposes to centralize IDE coverage decisions, so that they are made by CMS rather than by Medicare contractors.

**Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)**

Currently, a referral for ultrasound screening for AAA must occur as part of an initial preventive physical examination (IPPE). The IPPE must be furnished not more than one year after the effective date of the beneficiary’s first Part B coverage period. Since the screening is a one-time benefit, a beneficiary who does not receive a referral within the one-year window becomes ineligible to receive the service. CMS proposes to modify the Medicare coverage rules to eliminate the implicit one-year time limit.
applicable to this service. This proposal would allow coverage of AAA screening for eligible beneficiaries without requiring them to receive a referral as part of the IPPE.

**Modifications to Coverage of Screening Fecal Occult Blood Tests (FOBT)**

CMS proposes to revise Medicare coverage rules to allow additional providers beyond an attending physician, such as a physician assistant, nurse practitioner or clinical nurse specialist, to furnish written orders for screening FOBT. CMS believes this proposal would allow for expanded coverage and access to screening FOBT, particularly in rural areas. CMS invites comment regarding whether a practitioner permitted to order a screening FOBT must be the beneficiary’s attending practitioner.

**Extension of Ambulance Add-ons**

The rule implements the ATRA’s extensions to the existing add-on payments for ground ambulance services – a 3 percent add-on for rural areas and a 2 percent add-on for urban areas – through Dec. 31. It also extends through Dec. 31 the “super rural” ambulance add-on. These provisions are retroactive to Jan. 1, 2013. Without congressional action, add-on payments for ground ambulance services will expire on Dec. 31. The AHA will continue to urge Congress to extend ambulance add-on payments.

In addition, the rule implements an ATRA requirement that, for services furnished on or after Oct. 1, 2013, the ambulance fee schedule amount will be reduced by 10 percent for ambulance services consisting of non-emergency basic life support involving the transport of an individual with ESRD for renal dialysis services furnished on a non-emergency basis.

**Proposal to Update Payments under the Clinical Laboratory Fee Schedule**

In the proposed rule, CMS notes that the clinical laboratory fee schedule (CLFS), unlike other Medicare payment systems, lacks a mechanism to adjust payment amounts for the laboratory services that it covers (other than annual updates to previously determined payment amounts). Additionally, the agency reports that there has been a significant amount of technological change in the clinical laboratory area since the CLFS was first implemented, including laboratory-developed codes, increased use of point-of-care testing and new technologies, such as genetic and genomic tests. CMS wants to establish a process to reconsider payment amounts for laboratory tests that takes into account increased efficiency, changes in laboratory personnel and supplies necessary to conduct a test, changes in sites of service and other changes driven by technological advances.

Therefore, CMS proposes a detailed plan for reviewing all 1,250 existing codes on the CLFS over at least a five-year period. In this review, a key consideration will be technological changes, which CMS defines as changes to the tools, machines, supplies, labor, instruments, skills, techniques and devices by which laboratory tests are produced and used.
Under the proposed plan, CMS would conduct an annual review of CLFS codes, starting with the codes that have been on the CLFS the longest, to determine whether payment adjustments are warranted as a result of technological changes. CMS says it expects that most payment adjustments would decrease fee schedule amounts but that upward adjustments also might be proposed. CMS would issue a proposed rule discussing the technological changes for the specific test(s) for which the agency is proposing a payment adjustment and soliciting public feedback. The first round of this review would be finalized in the CY 2015 PFS final rule.

Once CMS has completed its review of current CLFS codes, the agency proposes to review codes added to the CLFS after 2015 that have been on the CLFS for at least five years. After the initial review of current CLFS codes is completed, CMS would allow the public to nominate additional codes for review.

**Liability for Overpayments**

Current law provides for waiver of recovery of overpayments to providers when the provider is “without fault” in the overpayment. In addition, recovery of overpayments to beneficiaries is waived if a beneficiary is without fault and recovery would be “against equity and good conscience.” Currently, there is a presumption that a provider or beneficiary is without fault and that the recovery is against equity and good conscience if the determination of an overpayment is made subsequent to the third year following the year in which the notice was sent stating that payment was made. The ATRA changed the presumption, so that it now applies when determination of an overpayment occurs subsequent to the fifth year following the year in which notice was sent that a payment was made. CMS proposes to modify regulations to reflect this statutory change.

CMS also proposes to modify current regulations to clarify that, under existing statute, the “against equity and good conscience” presumption for beneficiaries applies only with respect to certain denials, such as those for items and services that are not reasonable and necessary or that are for custodial care.

CMS estimates savings of $0.5 billion over 10 years as a result of these changes.

**Physician Quality Reporting System (PQRS)**

**Program Background.** PQRS is a pay-for-reporting program that ties the successful reporting of quality measures to payment incentives through CY 2014 and payment penalties beginning in CY 2015. To earn an incentive or avoid a penalty, individual eligible professionals (EPs) and group practices are required to report data on quality measures for covered services provided to Medicare Part B recipients during an applicable data reporting period. As finalized in the CY 2013 PFS rule, a “group practice” is defined as having two or more EPs, as identified by their National Provider Numbers (NPIs), who have reassigned their Medicare billing rights to a single Tax Identification Number (TIN).
Individual EPs may report quality measures using three mechanisms: recording quality data codes (QDCs) on Medicare claims, EHRs or qualified registries. Group practices may report PQRS measures using the mechanisms specified in the group practice reporting option (GPRO), including EHRs, qualified registries, or the GPRO’s web interface. However, a group practice also may choose not to participate in the PQRS GPRO, and instead elect to use the PQRS reporting mechanisms available to individual EPs.

In last year’s rule, CMS finalized the reporting requirements for individual EPs and group practices to earn the CY 2013 payment incentive. As in previous years, the incentive will be paid during the following calendar year (2014) after the agency has verified that a group or individual EP has successfully reported data. CMS also finalized its proposal to make the data reporting period used to determine PQRS payment penalties two years before the year in which the penalty is assessed. Thus, the data reporting periods for the CY 2015 and CY 2016 payment penalties are CY 2013 and CY 2014, respectively. Individual EPs and group practices that meet CY 2013 and CY 2014 PQRS reporting requirements will earn those years’ payment incentives, and avoid penalties in CY 2015 and CY 2016.

CMS proposes no changes to the previously finalized payment incentive and penalty levels for the PQRS program. However, the agency proposes several changes to the GPRO that affect CY 2014 incentives for reporting and, therefore, CY 2016 penalties. Notably, CMS proposes to allow smaller group practices to count patient experience survey reporting towards PQRS requirements and to increase the number of measures and domains group practices must report. CMS also proposes to allow individual EPs to participate in clinical data registries (which differ from the existing qualified registry reporting option) to meet PQRS requirements.

Payment Adjustments. As finalized in last year’s rule, individual EPs and group practices that successfully meet PQRS reporting requirements in CY 2014 may earn an incentive payment of 0.5 percent of their total estimated Part B allowed charges. CMS estimates that it will pay approximately $286 million in incentive payments for CY 2014 PQRS reporting. Beginning in 2015, physicians and other EPs will be subject to a payment penalty for not successfully reporting under the PQRS. This penalty is a negative 1.5 percent of total estimated Part B allowed charges and increases to negative 2.0 percent in 2016 and beyond.

Group Practice Size for GPRO Web Interface. Previously, group practices of 25 or more EPs were permitted to submit quality measure data using the GPRO web-interface reporting mechanism. In this year’s rule, CMS proposes to restrict the web-based reporting option to group practices of 100 or more EPs, thereby eliminating that reporting option for group practices of 25 to 99 EPs. The agency indicates that the web-interface reporting option has been largely unused by practices under 100 EPs.

GPRO Registration Deadline. Beginning with CY 2014 measure reporting, CMS proposes to change the deadline for group practices to self-register to participate in the PQRS GPRO. The deadline will move from the current date of Oct. 15 of the year in which the reporting period occurs to Sept. 30 of that year. For CY 2014 reporting, the
deadline would be Sep. 30, 2014. The agency proposes this change to allow more time to provide sample data for the GPRO web-interface reporting mechanism.

**GPRO Patient Experience Survey Reporting.** Beginning with CY 2014 reporting, CMS proposes to allow group practices of 25 or more EPs to count the reporting of the Clinician Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) towards PQRS requirements. To support this new option, the agency proposes to require the eligible group practices to collect and report CG CAHPS survey data using certified survey vendors. To obtain CMS certification, CG CAHPS survey administration vendors would be required to undergo training, comply with CMS’s survey administration processes and standards, and submit a quality assurance plan. Group practices that wish to report CG CAHPS survey data would be required to elect this option on the GPRO registration website.

**Measures and Domains Required for GPRO.** In the proposed rule, CMS indicates that it wishes to collect more comprehensive information to evaluate the performance of individual EPs and group practices. Thus, beginning with CY 2014 reporting, CMS proposes to increase the number of measures that group practices must report. Group practices of two or more EPs using the registry reporting option would be required to report nine measures (instead of the previous three) across at least three National Quality Strategy (NQS) domains. CMS maps each PQRS measure to the six NQS domains:

- Person and Caregiver-centered Experience and Outcomes
- Patient Safety
- Communication and Care Coordination
- Community/Population Health
- Efficiency and Cost Reduction
- Effective Clinical Care

Moreover, group practices using the registry reporting option must report each measure for at least 50 percent of the group practice’s applicable patients seen during the reporting period. Measures with a 0 percent score will not be counted toward the total number of measures. These proposed requirements are aligned with CMS’s proposals for individual EPs reporting using registries elsewhere in the rule.

As noted above, CMS proposes that group practices of 25 or more EPs may count CG CAHPS survey reporting towards meeting their requirements. For those groups reporting CG CAHPS data, CMS proposes to require the reporting of six other measures that cover at least two of the NQS domains. Moreover, **CMS proposes that groups electing to report CG CAHPS data must select one other reporting mechanism to submit the remaining measures.** Groups between 25 and 99 EPs could use the EHR and registry reporting options to report the six measures. Groups of 100 or more EPs also may use the GPRO web interface to report the measures. Table 1 summarizes the proposed changes to PQRS group practice reporting requirements for CY 2014.
Table 1: PQRS GPRO – Proposed Reporting Requirements for CY 2014 Payment Incentive and CY 2016 Payment Penalty

<table>
<thead>
<tr>
<th>Group Practice Size</th>
<th>Available Reporting Mechanisms</th>
<th>Reporting Requirement</th>
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| 2 or more EPs       | • Qualified Registry             | • Report at least 9 measures in at least 3 NQS domains.  
                      |                                 | • Include at least 50% of applicable patients |
| 25 – 99 EPs         | • Qualified Registry             | If only using Qualified Registry:  
                      | • Certified CG CAHPS vendor       | • Report at least 9 measures in at least three NQS domains.  
                      | • EHR Reporting                   | • Include at least 50% of applicable patients |
|                     |                                 | If submitting CG CAHPS:  
                      |                                 | • Submit CG CAHPS using certified survey vendor |
|                     |                                 | • Report at least 6 measures in at least 2 NQS domains using registry or EHR mechanism |
| 100 or more EPs     | • Qualified Registry             | If only using Qualified Registry:  
                      | • Certified CG CAHPS vendor       | • Report at least 9 measures in at least 3 NQS domains.  
                      | • EHR Reporting                   | • Include at least 50% of applicable patients |
|                     | • GPRO web interface             | If submitting CG CAHPS:  
                      |                                 | • Submit CG CAHPS using certified survey vendor |
|                     |                                 | • Report at least 6 measures in at least 2 NQS domains using registry, EHR or GPRO web interface |
|                     |                                 | If using only the GPRO web interface:  
                      |                                 | • Report on all PQRS GPRO measures included in the Web Interface  
                      |                                 |   o Populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group’s sample (with an over sample of 534) for each module or patient care measures.  
                      |                                 |   o If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries |

Qualified Clinical Data Registry Reporting Option for Individual EPs. As mandated by the ATRA, CMS proposes to add a new mechanism for individual EPs to satisfy PQRS program requirements – participation in a CMS-qualified clinical data registry. In the rule, the agency defines a qualified clinical data registry 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.” The rule proposes several requirements that
qualified clinical data registries must complete to obtain CMS certification for use in meeting PQRS program requirements.

CMS distinguishes the qualified clinical data registry option from the existing “qualified registry” option by noting that clinical data registries are expected to meet more challenging requirements. For example, qualified clinical data registries must have mechanisms for the transparency of data elements, measure specifications, risk models and benchmarking methods. Moreover, clinical data registries are expected to submit all-payer data on quality measures, not just Medicare patient data. However, CMS notes that entities that currently function as “qualified registries” also may serve as “qualified clinical data registries” if they meet CMS’s proposed requirements for clinical data registries.

PQRS Measures. The proposed rule provides several tables of measures proposed for reporting and removal from the PQRS program for CY 2014 reporting. Table 28 in the proposed rule lists the “core measures” CMS recommends for reporting in CY 2014.

Table 29 of the proposed rule lists the proposed individual PQRS measures available for reporting beginning in CY 2014, along with the reporting mechanism, NQS domain area and rationale for proposed inclusion. Notably, Table 29 includes seven measures from the Hospital Inpatient Quality Reporting (IQR) Program. CMS indicates that it has “retooled” these seven measures in response to feedback that IQR measures better reflect the care provided by hospital-based physicians. The agency solicits comment on whether it should retool additional IQR measures for use in PQRS.

Physician Value-Based Payment Modifier (VBM) and the Physician Feedback Reporting Program

The ACA requires CMS to implement a VBM that would apply to Medicare fee-for-service payments starting with certain physicians on Jan. 1, 2015, and affect all physicians and physician groups by Jan. 1, 2017. The modifier would result in differential physician payments based on the quality of care provided and the cost of that care. In addition, after January 2017, the Secretary has the discretion to apply the VBM to payments for other eligible professionals, such as physician assistants and nurse practitioners. The law did not specify the amount of the VBM, only that the VBM program must be budget neutral.

The CY 2013 PFS final rule established the program’s foundations, including eligibility, data reporting periods, measures and methods used to calculate performance. The VBM is determined using the same measure data and reporting periods (two years prior to the year in which the VBM is applied) as the PQRS penalty. Thus, the data reporting periods for CY 2015 and CY 2016 are CY 2013 and CY 2014, respectively. Last year’s rule finalized the requirements for the CY 2015 VBM, so this year’s rule proposes changes affecting CY 2016 VBM determination. Specifically, CMS proposes to include more group practices, increase the potential payment penalty and change the measures used to calculate quality and cost.
Size of Group Eligible for CY 2016 VBM. As part of its plan to gradually increase the participation of physicians in the VBM, CMS proposes to reduce the group practice size eligible for the VBM from 100 EPs to 10 EPs in CY 2016. CMS believes that reducing the size of group practice eligible for the VBM will result in 58.4 percent of physicians being included in the VBM for CY 2016. For CY 2015, the group size will remain at 100 or more EPs.

CMS also proposes a minor change to the mechanism used to identify eligible group practices for CY 2016. CMS will continue to run a query of the Medicare provider online enrollment system – Provider Enrollment, Chain and Ownership System (PECOS). However, instead of running the query on Oct. 15 of each year, the agency proposes to run the query within 10 days of the close of PQRS GPRO registration during a relevant performance year. For example, the performance year for the CY 2016 VBM is CY 2014, and the proposed GPRO registration deadline is Sep. 30, 2014. Thus, CMS would run its PECOS query within 10 days of Sep. 30, 2014.

PQRS Participation Requirements. For CY 2016, CMS proposes to continue classifying physician groups into two different categories that affect the level of potential payment penalty: physician groups that have successfully reported PQRS measures (“Category 1”) and physician groups that have not successfully reported PQRS measures (“Category 2”). CMS also proposes to continue its policy of subjecting groups that have not satisfied PQRS reporting requirements to the maximum VBM payment penalty.

However, for the purposes of the CY 2016 VBM, CMS proposes two mechanisms for eligible group practices to report PQRS measures:

- **Submit measures using the PQRS GPRO in CY 2014.** CMS proposes that eligible groups can continue to use the PQRS’s GPRO. Groups may use any of the submission mechanisms allowed in the GPRO (see Table 1 on p. 13 of this advisory for a summary of the proposed GPRO mechanisms).

- **Submit measures as individual EPs in CY 2014.** There are some group practices that may not self-register to report PQRS data using the GPRO. Therefore, CMS proposes that if at least 70 percent of a group practice’s EPs meet the PQRS reporting requirements for individual EPs in CY 2014, that group also would satisfy the PQRS reporting requirement for the VBM. CMS notes that the majority of EPs participate in PQRS as individuals, and that the proposed option would enable them to continue individual PQRS participation if they so chose.

Payment Adjustment. CMS proposes to increase the maximum downward payment adjustment from 1 percent in CY 2015 to 2 percent for the CY 2016 VBM program. This maximum penalty would apply to groups that have not successfully participated in the PQRS, as well as to groups that score as poor performers using CMS’s VBM scoring methodology, the Quality Tiering Model (QTM).
The QTM’s overall methodology was finalized in the CY 2013 PFS rule. To determine a group practice’s VBM score, the QTM calculates two composite scores – one based on the quality measures reported by the group, and another based on cost measures calculated by CMS. The QTM compares the quality of care composite score with the cost composite score, and classifies both scores into high, average and low performance categories.

Since CMS does not know in advance how much money will be available to pay out in bonuses (the VBM program must be budget neutral), it has derived a “payment adjustment factor.” CMS will establish the upward (bonus) payment adjustment factor (“x”) after the performance period has ended based on the aggregate amount of downward payment adjustments. The proposed payment adjustment factors for each of the categories of the QTM in CY 2016 are provided in Table 2.

<table>
<thead>
<tr>
<th>Table 2: Proposed CY 2016 VBM Payment Adjustments Using the QTM</th>
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</thead>
<tbody>
<tr>
<td><strong>High Quality</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Average Quality</strong></td>
</tr>
<tr>
<td><strong>Low Quality</strong></td>
</tr>
</tbody>
</table>

As finalized in the CY 2013 rule, CMS will continue to apply an additional incentive for groups to provide care to high-risk beneficiaries to ensure that the VBM program does not have negative unintended consequences. Specifically, CMS will increase the upward payment adjustment by +1.0x for groups that care for high-risk patients (as evidenced by hierarchical condition category, or HCC, risk scores). For example, a group practice that earned +2.0x for its high-quality, low-cost QTM, would be eligible for a +3.0x adjustment if it cared for a significant number of high-risk patients.

CMS proposes two notable changes to how the QTM will be used in payment adjustment determination for CY 2016:

- **All groups of 10 or more EPs that successfully meet PQRS participation requirements in CY 2014 must be scored on the QTM for the CY 2016 VBM and have their payment adjustments tied to QTM scores.** Previously, groups that met the PQRS participation requirement could opt out of QTM scoring, thereby receiving neither an upward or downward payment adjustment.

- **However, groups of between 10 and 99 EPs that successfully meet PQRS reporting requirements in CY 2014 would not be subject to a negative payment adjustment.** Such groups would receive either a positive or 0 percent payment adjustment.

Lastly, as finalized in the CY 2013 rule, CY 2015 and CY 2016 VBM payment adjustments will not apply to groups of physicians participating in the Medicare Shared Savings Program (MSSP), the Pioneer ACO model, or other similar Innovation Center or CMS initiatives, such as the Comprehensive Primary Care Initiative.
**Data Reporting Period.** CMS previously finalized CY 2014 as the measure performance period for the CY 2016 VBM program. CMS proposes to use CY 2015 as the performance period for the CY 2017 VBM program.

**Quality Measures.** To calculate the quality composite score for the CY 2016 VBM, CMS proposes to use data collected from all CY 2014 PQRS reporting mechanisms for both GPRO and individual EP reporting. For additional information on proposed CY 2014 GPRO reporting, see the PQRS section of this advisory. CMS also proposes to continue calculating three additional quality outcome measures that are included in the quality composite score:

- **Acute Condition Composite.** Combines the rates of potentially preventable hospital admissions for dehydration, urinary tract infections and bacterial pneumonia.
- **Chronic Condition Composite.** Combines the rates of potentially preventable hospital admissions for diabetes, heart failure and chronic obstructive pulmonary disorder (COPD).
- **All-Cause All-Condition Hospital Readmission Measure.** Assesses the rate of hospital readmissions among the group practice’s population.

CMS makes two notable proposals for using PQRS data reported by individual EPs to calculate the VBM quality composite. First, for groups that successfully report as individual EPs, CMS proposes to calculate the group’s performance on measures by combining the weighted average of rates for the individual EPs that report the measure. Second, if all individual EPs opt to report measures using the newly proposed clinical data registry option, CMS proposes to score the quality composite as “average” if it cannot obtain adequate data from the clinical data registry.

**Cost Measures.** In the CY 2012 PFS final rule, CMS finalized five cost measures for the VBM program: total per capita spending per beneficiary and per capita spending for four specific conditions – COPD, coronary artery disease, heart failure and diabetes. The total per capita spending measure includes costs under both Medicare Part A and Part B. CMS puts the four condition-specific cost measures into one domain and the total per capita cost measure into another domain. Weighting each domain equally, CMS calculates a composite “cost” score for the VBM. For the CY 2016 VBM, CMS proposes to add the same Medicare spending per beneficiary (MSPB) measure that it currently uses in the hospital IQR and value-based purchasing (VBP) programs. The MSPB measure would be added to the same measure domain as the total per capita cost measure.

**Medicare Spending per Beneficiary.** The MSPB measure includes all Medicare Part A and Part B payments during a care episode. CMS defines a care “episode” as three days prior to an index admission to a subsection (d) hospital (or general, acute care, short-term, hospital) through 30 days post discharge. The payments for each episode are risk-adjusted to account for age and severity of illness. The payment amounts captured in the measure are “standardized,” in that the effects of geographic payment adjustments and other payment factors are removed.
**MSPB Score used for VBM.** In its two hospital measurement programs (IQR and VBP), CMS derives a hospital’s MSPB score using a three-step calculation. For the purposes of VBM, however, CMS proposes to use a two-step calculation:

1. CMS first creates a ratio by dividing the total standardized payments for all index hospital admissions by an “expected” payment amount that is calculated using the measure’s risk adjustment model.

2. CMS then multiplies the ratio in step 1 by the national median MSPB episode code to calculate a physician group’s MSPB amount.

Unlike the MSPB measure used in the IQR and VBP, CMS will not calculate a ratio of a group’s MSPB amount to the national MSPB amount. Instead, the MSPB amount will be considered a physician group’s performance rate.

**MSPB Attribution to Physician Groups.** The attribution of MSPB episodes to physician groups is complex because physicians within a group may be involved with a patient’s inpatient care, post-discharge care, or both during a given episode. For the VBM, CMS proposes to attribute an MSPB episode to a physician group when any EP in the group submits a Medicare Part B claim under the group’s TIN for services provided during the episode’s index hospitalization. The services would need to be provided during the VBM performance period. Because of this attribution methodology, it is possible for the same index admission and corresponding MSPB episode to be attributed to more than one physician group. CMS believes that this attribution model will encourage greater coordination of care between physicians and hospitals and enable more than 11,000 physician groups to be scored on the measure.

CMS also solicits comment on potential alternative scoring methodologies. For example, CMS could attribute a MSPB episode to a group if an EP in a group submits a claim for services provided at any time during the episode. CMS also could attribute a MSPB episode only to the group providing a plurality of Part B services during the entire episode or hospitalization (i.e., the highest total dollar amount of Medicare Part B services of any group of physicians).

**MSPB Reliability Standard.** To ensure that MSPB costs captured by the measure are due to true variation in costs rather than random variation, CMS proposes that a physician group would need a minimum of 20 MSPB episodes attributable to them during the VBM performance period.

**Other Cost Composite Measure Updates.** CMS also proposes to update its methodology to adjust measure scores for differences in physician group specialty mix using a “specialty adjustment” methodology. First, CMS would calculate national specialty-specific expected costs for each measure. Next, the agency would determine the specialty mix of each group, and calculate a “specialty-adjusted expected cost.” This cost is a weighted average of the national specialty-specific costs, where the weights are each specialty’s proportion of Part B payments within the group. Finally, CMS divides the total per capita cost of each group by the “specialty-adjusted expected cost,” multiplying the resulting ratio by the national average per capita cost. This final
result is a “specialty-adjusted total per capita cost” that CMS would use to determine whether a practice is high, average or low cost.

CMS also discusses an alternative adjustment methodology called “comparability peer grouping.” Instead of directly adjusting each group practice’s scores, CMS would segment physician practices into cohorts based on their specialty mix. CMS would then assign benchmarks to each cohort, and individual groups within the cohort would have their measure performance compared to their cohort, and not to an adjusted national average.

CMS also proposes that when it is unable to attribute the minimum number of beneficiaries (20) to a physician group to calculate the cost measure composite, the agency would classify the group as “average” in the QTM.

**Feedback Reports.** The proposed rule summarizes some enhancements to the Quality and Resource Use Report (QRUR) that CMS plans to incorporate into future reports. CMS plans to disseminate QRURs based on CY 2013 data to all physicians in late summer of 2014. These reports will include performance on the quality and cost measures used to score the composites of the VBM.

**Physician Compare Website**

CMS proposes a number of additions and changes to the Physician Compare website. Currently, the site includes the names of physicians, EPs and certain group practices that satisfactorily submit quality data for the PQRS as well as those who are successful e-prescribers. The ACA requires that physician performance information be available on the website by Jan. 1.

**Expansion of Public Reporting for Group Practices and ACOs.** For 2014, CMS proposes to expand Physician Compare reporting by including all measures collected through the PQRS GPRO web interface. Physician groups of all sizes participating in the GPRO web interface, as well as accountable care organizations (ACOs) participating in the MSSP, would be included in the reporting. To publicly display measure performance, CMS requires a minimum volume of 20 patients. Group practices will have a 30-day period to preview their measure performance before data are posted to Physician Compare.

CMS also proposes to publicly report measures for physician groups that use the GPRO registry reporting and EHR reporting options. This proposed reporting would begin no earlier than CY 2015. Lists of the measures that would be reported on Physician Compare under the registry and EHR reporting options are provided in Section (III)(G)(3) of the proposed rule.

**Patient Experience Survey Reporting.** Earlier this year, CMS initiated the collection of patient experience data through CG CAHPS survey for two groups: 1) group practices submitting data via the GPRO web interface, and 2) ACOs participating in MSSP. CMS administers the CG CAHPS surveys for these two groups based on a
sample of their beneficiaries. CMS proposes to continue publicly reporting CG CAHPS survey data for group practices and ACOs with more than 100 EPs.

However, CMS also proposes to publicly report CG CAHPS survey data for smaller group practices that voluntarily submit them to meet PQRS reporting requirements. The AHA will ask CMS to clarify the size of group practice for which it intends to publicly report CG CAHPS scores. In one part of the rule, the agency states it intends to “publicly report on patient experience measures for 2014…for group practices of 25 or more professionals…” However, elsewhere in the Physician Compare section of the proposed rule, CMS proposes to publicly report CAHPS scores for “…any group practice (regardless of size) that voluntarily chooses to report CG CAHPS.”

Public Reporting for Individual EPs. CMS makes a number of proposals to publicly report PQRS measures for individual EPs that do not participate in the PQRS’s GPRO. Individual EPs may report PQRS quality measures using registries, EHRs and claims data. CMS proposes to report data on 20 measures collected during CY 2014 for individual EPs. The specific measures are listed in Section (III)(G)(3) of the rule. CMS also proposes to publicly report CG CAHPS survey scores for individual EPs, beginning in 2015. Finally, CMS proposes to publicly report whether individual EPs participate in initiatives such as the American Board of Internal Medicine’s Choosing Wisely campaign.

EHR Incentive Program for EPs

Proposed Qualified Clinical Data Registry Reporting Option. CMS proposes to allow EPs beyond their first year in the Medicare EHR Incentive Program to submit electronic clinical quality measures (eCQMs) using qualified clinical data registries. In doing so, they would meet the requirements of the 2014 PQRS incentive and also satisfactorily meet the eCQM reporting requirements for the Medicare EHR Incentive Program for CY 2014. Under the proposal, the EP would be required to ensure that the selected registry has technology certified for the eCQM functionality that it intends to use. In addition, EPs must include a certified module in their EHR that meets the eCQM reporting criteria.

CMS notes that the reporting periods established in the EHR Incentive Program Stage 2 final rule would continue to apply to EPs who would choose to report eCQMs under this proposed qualified clinical data registry reporting option. However, this may not satisfy requirements for other quality reporting programs that have 12-month reporting periods, such as the PQRS.

Additionally, to avoid a payment adjustment, EPs who are in their first year of demonstrating meaningful use must satisfy their eCQM reporting requirements by Oct. 1 of the preceding year (for example, by Oct. 1, 2014 to avoid a payment adjustment in 2015). Therefore, CMS proposes that first-time meaningful users would not be able to use this registry reporting option and must report eCQMs via attestation as established in the meaningful use Stage 2 final rule, in order to avoid a potential mismatch with reporting deadlines previously stated in the meaningful use rule.
While the option to report once and fulfill reporting requirements across programs is commendable, CMS’s proposal raises several concerns about the continued non-alignment of the reporting requirements across programs and the lack of readiness to adopt a flexible regulatory approach that allows providers to choose among varied and acceptable pathways to meet program metrics.

**Proposed Group Reporting Option – Comprehensive Primary Care Initiative.**
Beginning in CY 2014, CMS proposes to add a group reporting option for eCQMs in the Medicare EHR Incentive Program for EPs who are part of a Comprehensive Primary Care (CPC) Initiative practice site. CPC practice sites submit a subset of the eCQMs that are included in the EHR Incentive Program for EPs to report. Under the group reporting option, each of the EPs in the CPC practice site would satisfy the eCQM reporting component of the Medicare EHR Incentive Program for the relevant reporting period if the CPC practice site successfully submits and meets the reporting requirements of the CPC Initiative. Only EPs beyond their first year of demonstrating meaningful use would be eligible to use the proposed CPC group reporting option. EPs who successfully submit as part of a CPC practice site using certified EHRs would satisfy their eCQM reporting requirement for the Medicare EHR Incentive Program. The CPC practice sites must submit the eCQM data in the form and manner required by the CPC Initiative. CMS invites comment on this proposal.

**Reporting of Electronically Specified Clinical Quality Measures for the Medicare EHR Incentive Program.** CMS proposes to require EPs participating in the Medicare EHR Incentive Program to report eCQMs in accordance with the most recent version of the eCQM specifications or report eCQMs via attestation, due to CMS’s inability to receive reports using different versions of the specifications. The proposed rule seeks comment on the likely availability of upgraded technology with upgraded eCQM specifications prior to the start of the CY 2014 reporting period. CMS also seeks comment on the data and/or logic dependencies in the eCQMs that would result in inaccurate measures if eCQM specifications and EHR technology were upgraded in the middle of a reporting period. This raises concerns about the government’s operational readiness to support the regulatory requirements included in the Medicare EHR Incentive Program. Additionally, the AHA remains concerned about the maturity of the process to develop, test and implement eCQMs.

**Medicare Shared Savings Program**

**Alignment with PQRS GPRO.** For CY 2014 reporting (and the CY 2016 payment adjustment), CMS proposes to continue aligning the reporting requirements for ACOs participating in the MSSP with the requirements of the PQRS GPRO. That is, ACOs must successfully submit data on 22 measures via the GPRO web interface to avoid being subject to a payment penalty under the PQRS. This successful reporting would allow ACOs to meet both MSSP and PQRS requirements because the MSSP requires the reporting of the same 22 measures. Moreover, CMS proposes to continue requiring EPs participate in measure reporting only under their ACO’s TIN.
Quality Measure Benchmark Data Sources. CMS previously proposed to calculate quality benchmarks under the MSSP using national Medicare Advantage and fee-for-service Medicare performance data. For the CY 2014 reporting period, CMS also proposes to incorporate data submitted by ACOs from both the MSSP and the Pioneer ACO programs.

Spreading Clustered Quality Measure Performance. CMS notes that data from the GPRO and the Physician Group Practice Demonstration suggest that quality measure performance across organizations can be tightly clustered around the same scores. For example, it is possible for there to be less than 2 percentage points between the 30th and 90th percentiles of performance across organizations. The agency notes that it is desirable to use actual performance data to compare organizations because it helps create understandable benchmarks. Nevertheless, in the context of a program that pays providers differentially based on quality, CMS states that allowing clustered performance rates for measures “may result in payments differences not associated with clinically meaningful differences” in quality of care. Therefore, CMS proposes a methodology to “spread” performance on quality measures whose scores across ACOs are tightly clustered.

Definition of Clustered Performance. CMS proposes to define a “tightly clustered” measure as one whose performance scores across ACOs have a less than a 6-percentage point spread between the 30th and 90th percentiles. CMS proposes these percentiles as the upper and lower bounds because the 30th percentile is the “minimum attainment” level below which an ACO does not receive points for quality performance. Similarly, ACOs achieve full points if they score at the 90th percentile or better. CMS also solicits comment on whether it should propose a wider spread between the 30th and 90th percentiles, such as 10 percentage points.

CMS proposes that the methodology to reduce clustering would not be applied to measures calculated as ratios (e.g., readmissions).

Methodology to Increase Spread. To increase the spread of scores across percentiles, CMS proposes to use the 60th percentile as a starting point. CMS would then create “spread” by increasing or decreasing the 60th percentile score by one point for each decile between the 30th and 90th percentiles.

CMS demonstrates this process in the example in Table 3 below. The example assumes that before adjustment, the 30th percentile of performance is 75.83, the 60th percentile is 77.15 and the 90th percentile is 79.23. When the adjustment is applied, the 60th percentile of performance does not change. However, CMS subtracts 1 percentage point from the 60th percentile score for each decile from the 50th to the 30th percentiles. Similarly, CMS adds 1 percentage point to the 60th percentile score for each decile above the 60th percentile.
Table 3: Proposed Methodology to Increase Measure Spread

<table>
<thead>
<tr>
<th>Percentile</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60 (start point)</th>
<th>70</th>
<th>80</th>
<th>90</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original performance rates</td>
<td>75.83</td>
<td>76.21</td>
<td>76.76</td>
<td>77.15</td>
<td>77.65</td>
<td>78.21</td>
<td>79.23</td>
</tr>
<tr>
<td>Performance rates using methodology to reduce clustering</td>
<td>74.15</td>
<td>75.15</td>
<td>76.15</td>
<td>77.15</td>
<td>78.15</td>
<td>79.15</td>
<td>80.15</td>
</tr>
</tbody>
</table>

As an alternative to the fixed-point spread methodology outlined above, CMS proposes that the spread between a measure’s percentiles of performance could be based on the historical distribution of ACO performance, and not that of other data sources. CMS notes that this alternative approach to increasing spread assumes that ACOs have a different distribution of performance than other organizations.

**NEXT STEPS**

The AHA encourages members to submit comments on how CMS’s proposals will affect their facility. Watch for more information from the AHA that may assist you in preparing your organization’s comment letter.

Comments are due Sept. 6 by 5 p.m. ET and may be submitted electronically at [http://www.regulations.gov](http://www.regulations.gov). Follow the instructions for “submitting a comment.”

CMS also accepts written comments (an original and two copies) via regular or overnight/express mail.

**Via regular mail**
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Please contact Melissa Jackson, AHA senior associate director of policy, at (202) 626-2356 or mjackson@aha.org with further questions.