# Medicare Physician Fee Schedule (PFS) 2015 Proposed Rule: Changes to Physician Quality Programs

*Questions and Answers*

## Background

Consistent with its annual regulatory cycle, the Centers for Medicare & Medicaid Services (CMS) issued the 2015 Medicare PFS Proposed Rule (Proposed Rule) on July 3, 2014. The Proposed Rule was published in the Federal Register on July 11, 2014, and outlines policies and payment rates for Medicare Part B physician services that, if adopted, will become effective for calendar year (CY) 2015.[1] This Questions and Answers (Q&A) document addresses changes to various Medicare physician quality programs presented in the 2015 Proposed Rule. A separate Q&A focuses on the Proposed Rule's coding and payment policy proposals.

***Q. How would the Proposed Rule impact the various Medicare physician quality programs?***

**A.** The Proposed Rule would make a number of changes and refinements to Medicare physician quality programs and emphasizes the agency's intent to facilitate the alignment of programs, reporting systems, and quality measures. The specific quality-related areas discussed in the Proposed Rule include:

- The Physician Quality Reporting System (PQRS);
- The Physician Value-Based Payment Modifier (VBPM);
- The Medicare Shared Savings Program; and
- Physician Compare.

[1] CMS, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models, and Other Revisions to Part B for CY 2015, Proposed Rule, 79 Fed. Reg. 40,318 (July 11, 2014).

## I. Physician Quality Reporting System (PQRS)

### *Q. What is the PQRS?*

**A.** The PQRS began in 2007 as a way for CMS to collect data on specific disease states and financially reward eligible professionals (EPs) for reporting quality measures. Currently, the PQRS remains a voluntary, stand-alone program. The PQRS has expanded and evolved over time, and has served as the foundation for other Medicare value-based programs, including the VBPM and Shared Savings Program.

PQRS participants must satisfactorily report data on quality measures for covered PFS services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries. The PQRS program is updated annually, with changes effective the first day of each new calendar year. The performance period is two years prior to the payment adjustment period (e.g., 2015 performance will determine the 2017 PQRS payment adjustment). Program requirements and measure specifications may change each year.

Through performance year 2014, successful participation in PQRS qualifies EPs for an incentive payment equal to 0.5% of the total estimated Medicare Part B PFS allowed charges for covered professional services (excluding drugs and biologicals) furnished during the applicable reporting period. Beginning in 2015, however, PQRS participation will no longer earn an incentive. Rather, failure to participate in PQRS will result in a PFS payment reduction. PQRS payment adjustments are additive to those of other quality programs (i.e., the VBPM and Medicare Electronic Health Record (EHR) Incentive Program), potentially reducing PFS payment to a physician by as much as 9% by 2017 when the effects of all three programs are combined.[2]

Requirements for successful participation in PQRS are specific to the reporting method. CMS publishes tools and resources to assist providers with PQRS. The CMS PQRS home page may be accessed at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRI/01_Overview.asp.

[2] CMS, EHR Incentive Program: Payment Adjustments & Hardship Exceptions Tipsheet for Eligible Professionals (Mar. 2014), *available at* http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PaymentAdj_HardshipExcepTipSheetforEP.pdf; 42 U.S.C. § 1395w–4(a)(8)(A)(ii); 79 Fed. Reg. at 40,506.

***Q. Would the Proposed Rule make any changes to PQRS measures?***

**A.** Yes, CMS proposes a number of updates to the PQRS measures, including:

- revisions to the PQRS measures set;
- introduction of a new, cross-cutting measures set; and
- changes to measures groups.

*Measures Set Revisions*

As is customary in the annual rulemaking cycle, the Proposed Rule would make revisions to the measures that will be available for satisfactory PQRS reporting beginning in 2015 and beyond. CMS is proposing to add 28 new individual measures and two measures groups, and to remove 73 measures, bringing the proposed PQRS individual measure set to 240 total measures.[3] The proposed measures are classified against six domains based on the National Quality Strategy's (NQS's) six priorities:

1. Patient Safety
2. Person and Caregiver-Centered Experience and Outcomes
3. Communication and Care Coordination
4. Effective Clinical Care
5. Community/Population Health, and
6. Efficiency and Cost Reduction.[4]

Proposed measure changes are not limited to additions and deletions, but also include domain reclassifications or changes to allowable reporting methods. Table 22 in the Proposed Rule lists the additional measures proposed for inclusion in the PQRS measure set for CY 2015 and beyond.[5] Table 23 specifies the measures for which CMS proposes an NQS domain change.[6]

[3] CMS, Fact Sheet: Changes for Calendar Year 2015 Physician Quality Programs and Other Programs in the Medicare Physician Fee Schedule, *available at* http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets.html.
[4] 79 Fed. Reg. at 40,401-02.
[5] 79 Fed. Reg. at 40,410-18 tbl. 22.
[6] 79 Fed. Reg. at 40,419-25 tbl. 23.

Table 24 lists the measures CMS would remove from PQRS reporting.[7] Table 25 specifies proposals to change the way in which previously established measures in the PQRS will be reported beginning in 2015, and Tables 48 and 49 specify measures proposed for deletion and addition to the Group Practice Reporting Option (GPRO) web interface.[8]

*Cross-Cutting Measures*

CMS proposes cross-cutting measures for the purpose of obtaining quality data on more varied aspects of an EP's practice. Cross-cutting measures are measures that are generally not disease or condition-specific such that they can be applied across a wide range of patients. The cross-cutting measures would apply to face-to-face encounters, which would be determined based on PFS billed services commonly associated with such encounters (e.g., general office visit codes, outpatient visits, and surgical procedures), but would not include telehealth visits.[9] Examples of cross-cutting measures include: influenza immunization, controlling high blood pressure, and screening for falls. Table 21 in the Proposed Rule contains the complete list of proposed cross-cutting measures.[10]

*Measures Groups*

A measures group is currently defined as a subset of four or more PQRS measures that have a particular clinical condition or focus in common. The denominator definition and coding of the measures group identifies the condition or focus that is shared across the measures within a particular measures group.[11] The Proposed Rule would increase the number of measures for defining a measures group as a subset of six or more PQRS measures that have a particular clinical condition or focus in common.[12]

The Proposed Rule would also add two new measures groups: 1) sinusitis, and 2) Acute Otitis Externa (AOE), and remove six current measures groups. The measures groups proposed for reporting in 2015 and beyond are specified in Tables 26-48.[13]

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[7] 79 Fed. Reg. at 40,426-40 tbl. 24.
[8] 79 Fed. Reg. at 40,441-56 tbl. 25; 40,469-72 tbls. 48 & 49.
[9] 79 Fed. Reg. at 40,395.
[10] 79 Fed. Reg. at 40,404-09 tbl. 21.
[11] 42 C.F.R. §414.90(b).
[12] 79 Fed. Reg. at 40,457.
[13] 79 Fed. Reg. at 40,457-40,468 tbls. 26-48.

***Q. Would the Proposed Rule make any changes to the PQRS reporting vehicles/entities?***

**A.** The PQRS includes the following reporting mechanisms: claims; qualified registry; EHR; GPRO web interface; certified survey vendors for Consumer Assessment of Healthcare Providers and Systems Clinical and Group Surveys (CG-CAHPS) survey measures; and the Qualified Clinical Data Registry (QCDR). CMS proposes changes to the registry, EHR, QCDR and the GPRO web interface reporting mechanisms, but does not propose changes to claims-based reporting.[14]

*Qualified Registries*

- CMS proposes that qualified registries be able to report on all cross-cutting measures (specified in Table 21) for which the registry's EPs are able to report.
- CMS proposes to extend the deadline for qualified registries to submit quality measures data from the last Friday in February to March 31 following the end of the applicable reporting period.
- CMS seeks comment on whether to propose in future rulemaking to allow more frequent submissions of data, such as quarterly or year-round submissions, rather than the current annual process.[15]

*EHR Data Submission*

- CMS would continue requirements for direct EHRs and EHR data submission vendors to comply with CMS Implementation Guides for data file formats.
- CMS would also ensure that data is derived from certified EHR technology (CEHRT), and proposes that the EP or group practice provide the CMS EHR Certification Number of the product used for direct EHRs and EHR data submission vendors.[16]

*QCDR Requirements*

- The Proposed Rule would expand the number of available outcome measures from one to three, or in lieu of three outcomes measures, provide two outcome measures and at

[14] 79 Fed. Reg. at 40,392.
[15] 79 Fed. Reg. at 40,392.
[16] 79 Fed. Reg. at 40,393.

least one of the following: resource use, patient experience of care, or efficiency/ appropriate use.
- CMS proposes to change the limit of non-PQRS measures that a QCDR may submit on behalf of an EP from 20 to 30 measures.
- The Proposed Rule would clarify the definition of a "non-PQRS measure" as a measure that is not contained in the PQRS measure set for the applicable reporting period or one that is included in the PQRS measure set but that is reported differently by the QCDR.
- CMS proposes to require that a QCDR entity make available to the public the quality measures data for which its EPs report. Options for reporting such measures would include Physician Compare or other public venues of the QCDR entity's choice (e.g., board or specialty websites, reports, etc.)[17]

*GPRO Web Interface*

- The Proposed Rule would move the deadline by which a group practice must register to participate in the GPRO from September 30 to June 30 of the year in which the reporting period occurs.
- CMS seeks comment on whether to propose in future rulemaking to allow more frequent submissions of data, such as quarterly or year-round submissions, rather than the current annual process.[18]

***Q. Would the Proposed Rule make any changes to the criteria for satisfactory PQRS reporting by EPs or groups?***

**A.** Reporting year 2014 is the last year in which a PQRS incentive may be earned. EPs who do not meet the criteria for satisfactory reporting or satisfactory participation during the 2015 performance period will be subject to the 2017 PQRS payment adjustment with no exceptions.[19] That payment adjustment is 98.5% of the PFS amount that would otherwise apply for professional services (does not include drugs or biologicals) furnished by an EP – in other words, a -1.5% penalty.[20]

[17] 79 Fed. Reg. at 40,393-94.
[18] 79 Fed. Reg. at 40,395.
[19] 79 Fed. Reg. at 40,392.
[20] 42 U.S.C. § 1395w–4(a)(8).

The Proposed Rule would alter some criteria for satisfactory 2015 PQRS reporting based on the reporting mechanism. The tables below (Tables 1 and 2) present summaries of the proposed changes, which would not go into effect unless CMS finalizes them in the 2015 Final Rule later this fall. For the complete 2014 PQRS reporting criteria, please refer to the PQRS website, at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRI/01_Overview.asp

**Table 1: Summary of *Proposed* Changes to 2015 PQRS Reporting Criteria for EPs**

| Measures Type | Reporting Method(s) | Proposed Reporting Criteria Changes |
|---|---|---|
| Individual | Claims<br>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 Medicare Part B FFS patients seen during the reporting period to which the measure applies<br>• If less than 9 measures apply, report up to 8 measures with the same 50% threshold<br>• If the EP sees at least 1 Medicare patient in a face-to-face encounter, report on at least 2 cross-cutting measures[21] |
| Individual | QCDR | • Report at least 9 measures that are reportable under a QCDR, covering at least 3 of the NQS domains AND report each measure for at least 50 % of the EP's patients<br>• If less than 9 measures apply, report up to 8 measures with the same 50% threshold<br>• Report on at least 3 outcome measures, OR if 3 are not available, report on at least 2 plus at least 1 related to resource use, patient experience of care, or efficient/appropriate use[22] |
| Individual | EHR | • Report 9 measures covering at least 3 of the NQS domains<br>• If an EP's CEHRT does not contain patient data for at least 9 measures in 3 domains, then report all of the measures for which there is Medicare patient data; required to report on at least 1 measure for which there is Medicare patient data[23] |

[21] 79 Fed. Reg. at 40,395-96.
[22] 79 Fed. Reg. at 40,396-97.
[23] 79 Fed. Reg. at 40,396.

## Table 2: Summary of *Proposed* Changes to 2015 PQRS Reporting Criteria for Groups

| Measures Type | Reporting Method | Proposed Reporting Criteria Changes |
|---|---|---|
| ***(Some reporting methods may be limited by group size)*** | | |
| Individual GPRO | GPRO interface | • Reduces the sample size for groups of 25 or more; report on all measures included in the web interface AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries<br>• If the pool of eligible assigned beneficiaries is less than 248, then the group practice would report on 100% of assigned beneficiaries<br>• Required to report on at least 1 measure for which there is Medicare patient data[24] |
| Individual GPRO | Qualified registry | • Report at least 9 measures covering at least 3 of the NQS domains<br>• If less than 9 measures apply, report up to 8 measures with the same 50% threshold<br>• If a group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice would be required to report on at least 2 cross-cutting measures<br>• Subject a group practice to the measure-applicability analysis (MAV) process – the process CMS uses to determine whether EPs could have reported applicable quality measures or domains – if they do not report 1 cross-cutting measure and have seen at least 1 Medicare patient in a face-to-face encounter[25] |
| Individual GPRO | EHR | • Report 9 measures covering at least 3 of the NQS domains<br>• If a Group's CEHRT does not contain patient data for at least 9 measures in 3 domains, then report all of the measures for which there is Medicare patient data<br>• Required to report on at least 1 measure for which there is Medicare patient data[26] |

[24] 79 Fed. Reg. at 40,397-98.
[25] 79 Fed. Reg. at 40,398-99.
[26] 79 Fed. Reg. at 40,399.

## II. Value-Based Payment Modifier

### *Q. What is the VBPM?*

**A.** Healthcare reform required that the Secretary of Health and Human Services establish a payment modifier providing for differential payment for a physician or group of physicians based on their performance on quality of care measures compared to cost measures during a performance period.[27] The modifier applies to certain physicians and physician groups beginning in 2015, and is required to apply to all physicians and physician groups beginning in 2017. The VBPM applies only to Part B physician payments under the Medicare PFS. Thus, it does not apply to Medicare payments for drugs and biologicals. It is applied to the Medicare paid amount at the tax identification number (TIN) level, and does not impact beneficiary cost sharing.[28]

The VBPM must be budget neutral, so some physician and physician groups' payments will be increased and others will be decreased, with the total level of payment remaining unchanged. VBPM payment adjustments are additive to those of other Medicare physician quality programs (i.e., PQRS and the Medicare EHR Incentive Program). More information on the VBPM and links to the Quality Resource and Use Reports (QRURs), which are discussed in more detail below, are available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

### *Q. How would the Proposed Rule affect implementation of the VBPM?*

**A.** The Proposed Rule would complete the phase-in for the VBPM, sets forth the policies for the 2017 payment adjustments, and makes certain other revisions, including:

- applying the VBPM to all physicians;
- extending the VBPM to non-physician EPs;
- requiring that physicians be subject to the "quality-tiering" methodology;
- applying the VBPM to participants in the Shared Savings Program and others;
- increasing the maximum downward payment adjustment;

[27] Patient Protection and Affordable Act (ACA), Pub. L. No. 111-148, § 3007, 124 Stat. 119 (Mar. 23, 2010).
[28] 42 C.F.R. § 414.1205.

- revising the beneficiary attribution methodology; and
- expanding the current informal inquiry process.[29]

*Group Size and Composition*

The Proposed Rule would complete the VBPM phase-in by setting forth policies to apply the VBPM in 2017 and beyond to groups of two or more EPs and to all solo practitioners. Thus, by 2017, all Medicare physicians and physician groups would be subject to the VBPM, as required by law. CMS estimates that this latest expansion of the VBPM program would affect approximately 83,500 physician groups and 210,000 solo practitioners (as identified by their TIN), consisting of approximately 815,000 physicians and 315,000 non-physician EPs.[30]

*Extending the VBPM to Non-Physician EPs*

The Proposed Rule would expand application of the VBPM to non-physician EPs (i.e., nurse practitioners, physician assistants, physical therapists, and others) for the CY 2017 payment adjustment period and each subsequent year's adjustment period. As noted above, beginning with the CY 2017 payment adjustment period, the VBPM would apply to all of the EPs in groups with two or more and to EPs in solo practice. This would include groups comprised of only non-physician practitioners and solo non-physician practitioners.[31]

*Mandatory Quality-Tiering*

Under the VBPM quality-tiering process, participating EPs are subject to an upward, neutral, or downward payment adjustment depending on their performance on quality and cost measures compared to national benchmarks.[32] The Proposed Rule would make quality-tiering mandatory for all physicians and non-physician EPs. However, under this proposal, CMS would hold the newest participants – groups comprised of between two and nine EPs and solo practitioners – harmless from any downward payment adjustment in CY 2017.[33]

[29] 79 Fed. Reg. at 40,493.
[30] 79 Fed. Reg. at 40,493.
[31] 79 Fed. Reg. at 40,495-96.
[32] 42 C.F.R. § 414.1275.
[33] 79 Fed. Reg. at 40,497.

*Participants in the Shared Savings Program, Pioneer ACO and Other Innovation Initiatives*

For CY 2015 and 2016, groups of physicians participating in the Shared Savings Program, Pioneer ACO program, or other similar CMS or CMS Innovation Center initiatives, are not subject to the VBPM.[34] Under the Proposed Rule, beginning with the CY 2017 payment adjustment period, the VBPM would apply to all physician and non-physician EPs that also participate in the Shared Savings Program during the relevant performance period. CMS would classify the VBPM cost composite (determined based on the EP's combined performance on the applicable cost measures) for these groups as "average," citing the differences in how the cost benchmarks are calculated under the Shared Savings Program and VBPM. In addition, CMS proposes modifications to the VBPM quality composite scoring based on the EP's status in the Shared Savings Program (see Table 56 for a summary of proposed policies).[35] The quality composite reflects the EP's combined performance on the applicable quality measures. CMS further proposes that, beginning with the CY 2017 payment adjustment period, the VBPM would apply to physicians and non-physician EPs that participate in the Pioneer ACO program or the Comprehensive Primary Care Initiative during the 2015 performance period.[36]

*Payment Adjustments*

The Proposed Rule would increase the downward adjustment under the VBPM by doubling the amount of payment at risk from 2.0% in CY 2016 to 4.0% in CY 2017. In other words, CMS would apply a -4.0% adjustment to EPs who do not participate in PQRS in CY 2015. CMS would also increase the CY 2017 maximum downward adjustment under quality-tiering to -4.0% for practitioners classified as low quality/high cost, and set the adjustment to -2.0% for those classified as either low quality/average cost or average quality/high cost.[37]

The Rule would also increase the maximum upward adjustment in CY 2017 to +4.0× for those practitioners classified as high quality/low cost and to set the adjustment to +2.0× for those classified as either average quality/low cost or high quality/average cost, and to continue to provide an additional upward payment adjustment of +1.0× to groups and solo practitioners that care for high-risk beneficiaries.[38] Note that the "x" represents the upward adjustment factor,

[34] 42 C.F.R. § 414.1210.
[35] 79 Fed. Reg. at 40,498-99.
[36] 79 Fed. Reg. at 40,500.
[37] 79 Fed. Reg. at 40,505.
[38] 79 Fed. Reg. at 40,505-06.

which is calculated after the negative adjustments have been applied in order to keep the VBPM program budget neutral, as required by the statute.

*Beneficiary Attribution*

The Proposed Rule would modify the current beneficiary attribution methodology, as well as reverse the current exclusions of certain part-year Medicare beneficiaries. Both proposals would apply to the five per capita cost measures in the program. The change to the attribution methodology would also apply to the methodology used for claims-based quality measures.[39]

The proposed change to the current attribution methodology would remove the "pre-step" that now identifies a pool of assignable beneficiaries based on having had at least one primary care service furnished by a physician. Rather, beneficiaries would be assigned based on the plurality of primary care services in Step 1, with care available from physicians or non-physician practitioners.[40]

*Informal Inquiry Process*

Currently, EPs cannot seek administrative or judicial review of VBPM determinations, and CMS's current informal inquiry process is limited.[41] The Proposed Rule would expand this informal inquiry process and establish an initial process that would allow for some limited corrections to be made to the QRURs. For the 2015 adjustment, the proposed deadline for requesting corrections is January 31, 2015. However, CMS is seeking comment on an end of February deadline. If a CMS error is detected in the quality composite for the 2015 adjustment, the quality composite would be reclassified as "average," and the cost composite recalculated. For the 2016 adjustment and beyond, CMS proposes to have the operational infrastructure to recalculate both quality and cost.[42]

***Q. Does the Proposed Rule recommend any changes to the composition of the VBPM cost measures?***

[39] 79 Fed. Reg. at 40,510.
[40] 79 Fed. Reg. at 40,510.
[41] 42 C.F.R. §§ 414.1280; 414.1285.
[42] 79 Fed. Reg. at 40,508-09.

**A.** Medicare Part A and Part B costs are included in the VBPM total per capita cost measures and the Medicare Spending Per Beneficiary (MSPB) measure.[43] Medicare Part D costs are not included. In the Proposed Rule, CMS states that the agency is not proposing to include Part D data in the total per capita cost measures at this time due to the complexity of the issue. CMS goes on to state that, based on an estimated 60% of Medicare FFS beneficiaries being enrolled in stand-alone Part D plans in 2013, including Part D data would incorrectly indicate higher costs for these beneficiaries compared to those without Part D coverage. CMS encourages comments on methods for including Part D data in the total per capita cost measures.[44]

## III. The Medicare Shared Savings Program

### *Q. What is the Medicare Shared Savings Program?*

**A.** CMS established the Shared Savings Program to facilitate coordination and cooperation among providers in order to improve the quality and efficiency of care for Medicare FFS beneficiaries. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by establishing an Accountable Care Organization (ACO). The Shared Savings Program is designed to improve beneficiary outcomes and increase value of care by:

- Promoting accountability for the care of Medicare FFS beneficiaries;
- Requiring coordinated care for all services provided under Medicare FFS; and
- Encouraging investment in infrastructure and redesigned care processes.

The Shared Savings Program rewards ACOs that reduce costs for their patient population, while meeting performance standards on quality of care. Participation in an ACO is purely voluntary.[45]

### *Q. Would the Proposed Rule make any changes to ACOs?*

**A.** Although the Shared Savings Program is largely implemented through separate regulations, over the past few years, CMS has addressed certain quality-related provisions related to ACOs

[43] 42 C.F.R. § 414.1235.
[44] 79 Fed. Reg. at 40,511.
[45] CMS, Shared Savings Program, *available at* http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html.

in the annual PFS rulemaking. Citing ongoing efforts to align quality measurement and reporting under the Shared Savings Program with other Medicare quality programs (i.e., PQRS and the EHR Incentive), CMS has once again included several quality-related proposals for ACOs in the 2015 PFS Proposed Rule.[46]

*Quality Measures and Performance Standard*

The Proposed Rule would change the ACO quality measures to include more of a focus on outcomes, as well as attempt to reduce providers' reporting burden by incorporating more claims-based measures. Under these revisions, effective for the 2015 reporting period, ACOs would be evaluated based on 37 measures, an increase of four measures from the current 33 measures.[47] New measures would include: 1) all-cause, unplanned admissions for patients with diabetes; 2) heart failure and multiple chronic conditions; and 3) depression remission at 12 months. For a complete overview of the proposed changes, refer to Table 50 in the Rule.[48]

CMS also seeks comment on potential future quality measures, focusing on the following:

- Gaps in measures and additional specific measures;
- Caregiver experience of care;
- Alignment with VBPM measures;
- Specific measures to assess care in the frail elderly population;
- Utilization;
- Health outcomes; and
- Public health.[49]

CMS would also amend the regulations governing ACOs to align with the requirements previously adopted under the Medicare EHR Incentive Program.[50]

[46] 79 Fed. Reg. at 40,475.
[47] 79 Fed. Reg. at 40,477.
[48] 79 Fed. Reg. at 40,479-481 tbl. 50.
[49] 79 Fed. Reg. at 40,483-85.
[50] 79 Fed. Reg. at 40,486.

*Other Shared Savings Program Proposals*

The Proposed Rule contains additional proposals related to the Shared Savings Program:

- CMS proposes modifications to the benchmarking methodology for "topped out measures" – i.e., those for which all but a few organizations achieve near perfect scores. The new method would use an alternative methodology to establish the benchmark when the national FFS data result in the 90th percentile being greater than or equal to 95%. However, CMS requests comments on this proposal, including comments on whether the topped out measures should be dropped from the set entirely.[51]

- CMS proposes to revise its regulations so that ACOs entering a second or subsequent three-year participation agreement would continue to be evaluated on the quality performance standard that would otherwise apply to an ACO if it were in the third performance year of the first agreement period. This would be instead of reverting back to "pay for reporting," where ACOs meet the quality standard by simply reporting all applicable quality measures, which currently applies to the first year of the ACO participation agreement.[52]

- CMS proposes to update ACO benchmarks every 2 years.[53]

- CMS proposes to revise the existing quality scoring strategy to explicitly recognize and reward ACOs that make year-to-year improvements in their quality performance scores on individual measures. This methodology would add a quality measure that awards bonus points for improvement on each of the existing four quality measure domains. Up to two additional bonus points would be awarded to each domain for quality performance improvement on the measures within that domain.[54] CMS seeks comment on the proposed method as well as any suggested alternatives.

[51] 79 Fed. Reg. at 40,487-88.
[52] 79 Fed. Reg. at 40,488.
[53] 79 Fed. Reg. at 40,489.
[54] 79 Fed. Reg. at 40,490.

## IV. Physician Compare

### *Q. What is Physician Compare?*

**A.** Healthcare reform requires that physician quality performance information, including that collected under PQRS and related to patient experience of care, be made publicly available through the Physician Compare web site.[55] Launched in late 2010, Physician Compare (http://www.medicare.gov/physiciancompare/search.html) has evolved using a phase-in approach, gradually increasing the amount and type of information that is publicly available regarding Medicare physicians. Currently posted on the web site are the names of individual EPs who satisfactorily report under the PQRS, EPs who are successful electronic prescribers under the Medicare Electronic Prescribing (eRx) Incentive Program, and successful participants in the Medicare EHR Incentive Program. Quality performance reporting is in the early stages, and, so far, consists of reporting only at the group level. Performance scores are publicly available on the web site for five PQRS GPRO diabetes and heart disease measures for the group practices and Shared Savings Program ACOs that satisfactorily participated in these programs in 2012.[56]

CMS previously announced plans to expand the quality measures posted on Physician Compare with public reporting in CY 2015 of performance data on all measures collected through the GPRO web interface for groups of all sizes participating in 2014 under the PQRS GPRO and ACOs under the Medicare Shared Savings Program.[57] CMS also plans to publicly report group performance on certain PQRS measures submitted in 2014 via registries and EHRs, including patient experience of care.[58]

### *Q. Would the Proposed Rule make any changes to Physician Compare?*

**A.** The Proposed Rule would continue expansion of public reporting on Physician Compare by making more quality measures publicly available on the web site, including:

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[55] ACA § 10331(a)(2).

[56] CMS, Physician Compare , *available at* http://www.medicare.gov/physiciancompare/staticpages/data/pqrs.html and http://medicare.gov/physiciancompare/aco/search.html.

[57] Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Final Rule, 78 Fed. Reg. 74,230, 74,450 (Dec. 10, 2013).

[58] 78 Fed. Reg. at 74,451-52.

- all 2015 PQRS GPRO measure sets across group reporting mechanisms – GPRO web interface, registry, and EHR, for groups of 2 or more; and
- all measures reported by Shared Savings Program ACOs.

CMS seeks comment on creating composites (if technically feasible) using 2015 data and publishing composite scores in 2016 by grouping measures based on the PQRS GPRO measures groups, including but not limited to:

- Care Coordination/Patient Safety (CARE) Measures;
- Coronary Artery Disease (CAD) Disease Module;
- Diabetes Mellitus (DM) Disease Module; and
- Preventive (PREV) Care Measure.

In the future development of Physician Compare, CMS also proposes to:

- add benchmarks for 2015 PQRS GPRO data;
- begin reporting patient experience data for groups of 2 or more; and
- expand public reporting of quality data for individual EPs.[59]

CMS seeks comments on creating composites (if technically feasible) and publishing composite scores for individual EPs in 2016 by grouping measures based on the PQRS measures groups, including:

- Coronary Artery Disease;
- Diabetes Mellitus;
- General Surgery;
- Oncology;
- Preventive Care;
- Rheumatoid Arthritis; and
- Total Knee Replacement.[60]

Table 20 in the Proposed Rule presents a summary of the data proposed for public reporting.[61]

[59] 79 Fed. Reg. at 40,389-90.
[60] 79 Fed. Reg. at 40,390.
[61] 79 Fed. Reg. at 40,391 tbl. 20.

***Q. How can an interested individual or organization submit comments on the Proposed PFS Rule?***

**A.** Interested parties can submit comments either electronically, at http://www.regulations.gov, or by mail to:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1612–P
P.O. Box 8013
Baltimore, MD 21244-8013

Comments must be received by no later than 5 pm on September 2, 2014.