2014 Medicare Physician Fee Schedule Proposed Rule
Quality Provisions

The 2014 Medicare Physician Fee Schedule (MPFS) Notice of Proposed Rulemaking (NPRM) was
published in the Federal Register on July 19, 2013. Most policies are open to comment until
September 6, 2013 and scheduled to take effect on January 1, 2014. In addition to a number of policy
proposals related to reimbursement, the draft rule also includes many policy changes to various
Medicare quality improvement programs, including the Physician Quality Reporting System (PQRS),
the Medicare Electronic Health Record (EHR) Incentive program, as well as changes to the Physician
Compare tool on the Medicare.gov website. Finally, the rule continues the phased-in implementation
of the physician value-based payment modifier, created by the Affordable Care Act (ACA), that would
affect payments to physician groups based on the quality and cost of care they furnish to beneficiaries
enrolled in the traditional Medicare fee-for-service program. The MPFS Proposed Rule is available at:
http://1.usa.gov/17FW9KW. Below are some payment issues of interest to neurosurgeons:

Physician Compare
For 2014, CMS plans to expand the number of quality measures posted on Physician Compare by
publicly reporting on all measures collected through the group practice reporting option (GPRO) web
interface for groups of all physicians participating in 2014 under the PQRS GPRO and ACOs
participating in Medicare’s Shared Savings Program. Details include:

- Data will include measure performance rates for measures reported that meet the minimum
  sample size of 20 patients.
- CMS will provide a 30-day preview period prior to publication of quality data on Physician
  Compare.
- CMS will post performance on certain clinician and group Consumer Assessment of Healthcare
  Providers and Systems (CG-CAHPS) measures for groups of 100 or more participating in PQRS
  GPRO.
- To encourage groups of 25 or more eligible professionals (EPs) to report CG-CAHPS, CMS is
  proposing to make these measures available for reporting the PQRS and for the Value-Based
  Payment Modifier (VBPM).
- Publicly reporting CY 2014 CG-CAHPS data for any group practice (regardless of size) that
  voluntarily chooses to report CG-CAHPS. CMS will not fund surveys for groups under 100.

For calendar year 2015, CMS is seeking comment on whether to publicly report patient experience
survey data under the PQRS for individual physicians, starting with data reported in 2015 and to
publicly report participation by individual EPs on initiatives, such as Choosing Wisely. CMS is
proposing to post comparable data on the following individual measures collected for CY 2014 PQRS
via claims, EHR or registry from individual EPs (not many of which appear to be directly related to
neurosurgical practice):

- Diabetes: Hemoglobin A1c Poor Control
- Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- Medication Reconciliation
- Preventive Care and Screening: Influenza Immunization
- Pneumococcal Vaccination Status for Older Adults
- Preventive Care and Screening: Breast Cancer Screening
- Colorectal Cancer Screening
- Coronary Artery Disease (CAD): Angiotensin-converting Enzyme (ACE) Inhibitor or
  Angiotensin Receptor Blocker (ARB) Therapy -- Diabetes or Left Ventricular Systolic
  Dysfunction (LVEF < 40%)
- Adult Weight Screening and Follow-Up
- Preventive Care and Screening: Screening for Clinical Depression
Coronary Artery Disease (CAD): Lipid Control
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Hypertension (HTN): Controlling High Blood Pressure
- Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
- Falls: Screening for Fall Risk
- Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control
- Diabetes Mellitus: High Blood Pressure Control
- Diabetes Mellitus: Hemoglobin A1c Control (<8%)

**Physician Quality Reporting System (PQRS) Program**

CMS has proposed extensive changes for the PQRS program. Physicians who do not satisfactorily report in 2014 will receive a two percent payment cut (aka “adjustment”) for services provided under the Medicare physician fee schedule in 2016. However, for 2014 it is still possible for physicians to earn a PQRS 0.5% bonus; although the additional 0.5% MOC bonus payment will no longer be available.

Meeting the program requirements will be more difficult, as CMS is eliminating the options to either report at least one measure or report each measures group on at least 20 Medicare patients. Furthermore, part of CMS’ strategy will be to require reporting measures from among the six categories of the National Quality Strategy (NQS), which is as follows:

**The National Quality Strategy’s (NQS) Six Priorities**

1. **Person and Caregiver-Centered Experience and Outcomes.** These are measures that reflect the potential to improve patient-centered care and the quality of care delivered to patients. They emphasize the importance of collecting patient-reported data and the ability to impact care at the individual patient level as well as the population level through greater involvement of patients and families in decision making, self-care, activation, and understanding of their health condition and its effective management.

2. **Patient Safety.** These are measures that reflect the safe delivery of clinical services in both hospital and ambulatory settings and include processes that would reduce harm to patients and reduce burden of illness. These measures should enable longitudinal assessment of condition-specific, patient-focused episodes of care.

3. **Communication and Care Coordination.** These are measures that demonstrate appropriate and timely sharing of information and coordination of clinical and preventive services among health professionals in the care team and with patients, caregivers, and families to improve appropriate and timely patient and care team communication.

4. **Community/Population Health.** These are measures that reflect the use of clinical and preventive services and achieve improvements in the health of the population served. These are outcome-focused and have the ability to achieve longitudinal measurement that will demonstrate improvement or lack of improvement in the health of the US population.

5. **Efficiency and Cost Reduction.** These are measures that reflect efforts to significantly improve outcomes and reduce errors. These measures also impact and benefit a large number of patients and emphasize the use of evidence to best manage high priority conditions and determine appropriate use of healthcare resources.

6. **Effective Clinical Care.** These are measures that reflect clinical care processes closely linked to outcomes based on evidence and practice guidelines.
It is worth noting that the House Energy and Commerce Committee SGR-replacement proposal, also directly references these six categories, currently identifying them as “core competencies” in the quality measurement section of the draft bill.

The proposed PQRS program requirements are as follows:

**Individual PQRS Reporting**

- **Individual Claims Reporting.**\(^1\) Physicians must report at least 9 measures from the National Quality Strategy (NQS) covering 3 of the domains and each measure 50 percent of the time. If less than 9 apply, physicians must report 1-8 measures and report each measure on 50 percent of eligible patients. The reporting period is 12-months, from Jan. 1- Dec. 31. CMS is eliminating the measure group reporting option for purposes of the payment adjustment reporting requirements, and the agency is seeking comments on whether they should eliminate claims based reporting beginning with the reporting period (CY 2017) for the 2019 PQRS payment adjustment.
  - **Exception:** Individuals reporting via claims may report 3 measures and still avoid the payment adjustment for 2016 (not applicable for 2014 incentive).

- **Individual Qualified Registry Reporting.** Physicians must report at least 9 measures from the NQS covering 3 of the domains and report each measure 50 percent of the time. The reporting period is 12-months, from Jan. 1- Dec. 31.

- **Individual Qualified Clinical Data Registry.** Physicians must report at least 9 measures available for reporting under a qualified clinical data registry, covering at least 3 of the NQF domains and report each measure for at least 50 percent of the physician’s patients. At least one of these measures must be an outcomes measure. [see below additional details regarding the new qualified clinical data registry program]

**GPRO PQRS Reporting**

- **Qualified Registry.** A group of 2 or more eligible professionals must report at least 9 measures covering at least 3 of the NQS domains and report each measure for at least 50 percent of the group’s applicable patients seen during the reporting period for which the measure applies. The reporting period is 12-months, from Jan. 1- Dec. 31.

- **Certified Survey Vendor PLUS Qualified Registry; Direct EHR Product; EHR Data Submission Vendor; or GPRO Web Interface.** A group of 25 or more reports all CG CAHPS survey measures via a certified survey vendor and report at least 6 measures covering at least 2 of the NQS domains using the qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface reporting mechanisms.

**Changes to Measure Group Reporting**

CMS is proposing to modify the definition of a measures group to indicate that a measures group will consist of at least six measures. The agency is also proposing to add additional measures to those measures groups that previously contained less than six measures. The only way to report a measures group is through a registry.

- **Proposed Perioperative Care Measures Group for 2014 and Beyond**
  - Perioperative Care: Timing of Prophylactic Parenteral Antibiotic—Ordering Physician
  - Perioperative Care: Selection of Prophylactic Antibiotics—First or Second Generation Cephalosporin
  - Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)

\(^1\) Subject to measure application validation (MAV) strategy
- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in All Patients)
- Documentation of Current Medications in the Medical Record (new measure)
- Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention (new measure)
- Patient Centered Surgical Risk Assessment and Communication: The Percent of Patients who Underwent Non-Emergency Major Surgery Who Received Preoperative Risk Assessment for Procedure-Specific Postoperative Complications using a Data-Based, Patient-Specific Risk Calculator, and who also Received a Personal Discussion of Risk with the Surgeon (new measure)

**Proposed Back Pain Measures Group for 2014 and Beyond**
- Documentation of Current Medications in the Medical Record (new measure)
- Pain Assessment and Follow-Up (new measure)
- Back Pain: Initial Visit
- Back Pain: Physical Exam
- Back Pain: Advice for Normal Activities
- Back Pain: Advice Against Bed Rest

**Proposed New Optimizing Patient Exposure to Ionizing Radiation Measures Group for 2014 and Beyond (Only Reportable Through a Registry)**
- Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computed Tomography (CT) Imaging
- Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: CT and Cardiac Nuclear Medicine Studies
- Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry
- Optimizing Patient Exposure to Ionizing Radiation: CT Images Available for Patient Follow-Up and Comparison Purposes
- Optimizing Patient Exposure to Ionizing Radiation: Search for Prior CT Studies Through a Secure, Authorized, Media- Free, Shared Archive
- Optimizing Patient Exposure to Ionizing Radiation: Appropriateness Follow-Up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines

**Proposed Definition of a Qualified Clinical Data Registry**

Pursuant to the provisions contained in the American Taxpayer Relief Act (ATRA), CMS proposed to define a “qualified clinical data registry” for purposes of the PQRS as a CMS-approved entity (such as a registry, certification board, collaborative, etc.) that collects medical and/or clinical data for the purposes of patient and disease tracking to foster improvement in the quality of care furnished to patients. Additional requirements include:

**Benchmarking capacity.** The registry must have benchmarking capacity for assessing the care furnished to patients by the physician participating in the qualified clinical data registry. At a minimum, the registry must possess the capacity to benchmark performance across the physicians using the qualified clinical data registry. It must also possess a method to benchmark the quality of care measures that a physician provides with that of other physicians performing the same or similar functions. The qualified clinical data registry must provide metrics to compare the quality of care its participating physicians provide.

**Ability to provide timely and frequent feedback to its physicians.** The reports must be at least quarterly on the measures for which the qualified clinical data registry would report on individual physician’s behalf for the purposes of the physician meeting the criteria for satisfactorily reporting in PQRS.
• **Reporting data to CMS.** The registry must be able to submit quality measures data or results to CMS for purposes of demonstrating that, for a reporting period, its physicians have satisfactorily participated in PQRS. Furthermore, the data submitted to CMS for purposes of demonstrating satisfactory participation must be quality measures data on **multiple payers, not just Medicare.**

• **Registry data elements.** The registry must have in place mechanisms for the transparency of data elements and specifications, risk models and measures.

**Proposed Requirements for a Qualified Clinical Data Registry**

In addition to the basic requirements contained in the above definition, CMS is proposing the following requirements for a qualified clinical data registry:

• Must be in existence on Jan. 1, the year prior to the year for which the entity seeks to become a qualified clinical data registry.

• Must have at least 100 clinical data registry participants by Jan. 1, the year prior to the year for which the entity seeks to submit CQM data. Note, not all participants are required to participate in PQRS.

• Cannot be owned or managed by an individual, locally-owned, single specialty group.

• Must enter into and maintain with its participating professionals an appropriate Business Associate agreement.

• Must describe to CMS the cost for physicians that the qualified clinical data registry charges to submit data to CMS.

• The entity must describe to CMS its plan to maintain Data Privacy and Security for data transmission, storage and reporting.

• Must submit an acceptable validation strategy to CMS by March 31 of the reporting year the entity seeks qualification and perform the validation outlined in the strategy and send evidence of successful results to CMS by June 30 of the year following the reporting period.

• Must obtain and keep on file for at least seven years signed documentation that each holder of an NPI whose data are submitted to the qualified clinical data registry has authorized the registry to submit quality measure results and numerator and denominator data and/or patient-specific data on beneficiaries to CMS for the purpose of PQRS participation.

• Upon request, must provide CMS access to the qualified clinical data registry’s database to review the beneficiary data on which the qualified registry based submission are based or provide to CMS a copy of the actual data and must provide information on how the entity collects quality measures data, if requested.

• Prior to CMS posting the list of qualified registries for a particular year, must verify the information contained on the list.

• Must make available to CMS samples of patient level data to audit the entity for purposes of validating the data submitted to CMS by the qualified clinical data registry, if determined necessary.

• By March 31, of the year in which the entity seeks to participate in PQRS as a qualified clinical data registry, the entity must publically post (on the entity’s website or other public publication) a detailed description of the quality measures it collects to ensure transparency of information to the public.
• The entity must report on a set of measures from one or more of the following categories: CG-CAHPS; NQF endorsed measures; PQRS measures; measures used by boards or specialty societies; and measures used in regional quality collaboratives.

• The entity must demonstrate it has a plan to publicly report their quality data through a mechanism where the public and registry participants can view data about individual physicians, as well as view regional and national benchmarks. As an alternative, CMS is considering requiring the entity to benchmark within its own registry for purposes of determining relative quality performance where appropriate.

• The entity must demonstrate that it has a plan to risk adjust the quality measures data for which it collects and intends to transmit to CMS.

• Must be able to collect all needed data elements and transmit data on quality measures to CMS, upon request, in one of two formats, either via CMS-approved XML format or via the Quality Reporting Document Architecture (QRDA) category III format.

• Submit data to CMS no later than the last Friday occurring two months after the end of the respective reporting period (that is, February 27, 2015 for reporting periods occurring in 2014)

Requirements for the selection of PQRS Quality Measures for Qualified Clinical Data Registries for 2014 and Beyond

The proposal also outlines the detailed measurement requirements for qualified clinical data registries. These requirements are as follows:

• The registry must have at least 9 measures, covering at least 3 of the 6 NQS domains.

• The registry must have at least one outcome measure available for reporting, which is a measure that assesses the results of health care that are experienced by patients (that is, patients’ clinical events; patients’ recovery and health status; patients’ experiences in the health system; and efficiency/cost).

• The registry may report on process measures, which are measures that focus on a process which leads to a certain outcome.

• The outcome and process measures reported must contain denominator data. That is, the lower portion of a fraction used to calculate a rate, proportion or ratio. The denominator must describe the population eligible (or episode of care) to be evaluated by the measure. This should indicate age, condition, setting, and timeframe (when applicable).

• The outcome and process measures reported must contain numerator data. That is, the upper portion of a fraction used to calculate a rate, proportion, or ratio. The numerator must detail the quality clinical action expected that satisfied the condition and is the focus of the measurement for each patient, procedure, or other unit of measurement established by the denominator (that is, patients who received a particular service or providers that completed a specific outcome/process).

• The registry must provide denominator exceptions for the measures, where appropriate. That is, those conditions that should remove a patient, procedure or unit of measurement from the denominator of the performance rate only if the numerator criteria are met. Denominator exceptions allow for adjustment of the calculated score for those providers with higher risk populations. Denominator exceptions allow for the exercise of clinical judgment and should be specifically defined where capturing the information in a structured manner fits the clinical workflow. Generic denominator exception reasons used in measures falls into three general categories: Medical, Patient or System reasons.
The registry must provide denominator exclusion for the measures for which it will report to CMS, where appropriate.

The registry must provide to CMS descriptions for the measures for which it will report to CMS by no later than March 31, 2014. The description must include: name/title of measures, NQF # (if NQF endorsed), descriptions of the denominator, numerator, and when applicable, denominator exceptions and denominator exclusions of the measure.

CMS is still struggling with how to give physicians who participate in qualified clinical data registries credit for meeting the requirements of the Electronic Health Record Incentive (EHR) Program. In order for a physician to meet both the PQRS and EHR program quality measure requirements through registry reporting, the following criteria must be met:

- The quality measures reported must be those included in the Stage 2 final rule and the registry must use the same electronic specifications established for the EHR Incentive Program.
- Report 9 quality measures covering at least 3 NQS domains.
- If a physician’s certified EHR technology (CEHRT) doesn’t contain patient data for at least 9 clinical quality measures (CQMs) covering at least 3 domains, then the physician must report the CQMs for which there is patient data and report the remaining CQMs as “zero denominators” as displayed by the physician’s CEHRT.
- A physician must have CEHRT that is certified to all of the certification criteria required for CQMs, including certification of the qualified clinical data registry itself for the function it will fulfill (for example, calculation, electronic submission).
- This option is only available to physician’s who are beyond their first year of demonstrating meaningful use (MU).
- For purposes of avoiding a payment adjustment under Medicare, physicians who are in their first year of demonstrating MU in the year immediately preceding a payment adjustment must satisfy their CQM reporting requirements by Oct. 1 of such preceding year (for example, Oct. 1, 2014 to avoid a payment adjustment in 2015).

**Value-Based Modifier**

Under the Value-Based Payment Modifier (VBPM), physician reimbursement may be adjusted (in a budget neutral manner) upwards, downwards or neutral based on whether or not they meet certain quality and cost metrics. CMS will not apply the Value-Based Payment Modifier (VPBM) in CY 2015 and 2016 to any group of physicians that is participating in Medicare’s Shared Savings Program, the Pioneer ACO model or the Comprehensive Primary Care Initiative. The following information about the VPBM is noteworthy:

- CMS will increase the amount of payment at risk under the VBPM from one to two percent in CY 2016.
- A Medicare Spending Per Beneficiary (MSPB) measure will be included in the total per capita costs for all attributed beneficiaries domain of the cost composite.
- The cost measure benchmarking methodology will be refined to account for the specialties of the physicians in the group. There are two categories of groups:

  **Category 1 Groups:**
  - Groups that participate in the PQRS GPRO by any method (EHR, Registry, Web Interface) and meet criteria for the PQRS Payment Adjustment. If a group doesn’t participate in GPRO, then if 70 percent of the group’s physicians report individually, they will be assessed as a group.
Quality Tiering (up, down or no adjustment) will be mandatory for groups of 10 or more.

- Groups of 10-99 will not be subject to a downward adjustment
- Groups of 100 or more will be subject to upward, downward or neutral adjustment

The maximum downward is -2 percent (low quality/high cost) and -1 percent for low quality/average cost or average quality/high cost. Physicians taking care of highly complex patients will be eligible for additional upward adjustments of +1x and +2x^2 will be available, but budget neutrality will still need to be maintained.

Category 2 Groups:

These are groups that do not fall into Category 1, who will be subject to an automatic downward adjustment of -2 percent.

### 2016 Value-Based Payment Modifier Amounts

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<th>Average cost</th>
<th>High cost</th>
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<td>-1.0%</td>
</tr>
<tr>
<td>Low quality</td>
<td>+0.0%</td>
<td>-1.0%</td>
<td>-2.0%</td>
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- **Feedback Reports.** In September of 2013, CMS anticipates making available feedback reports to all groups of physicians of 25 or more based on 2012 data. In 2014, CMS anticipates providing feedback reports to all physicians.

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2 Groups of physicians eligible for an additional +1.0x if they are reporting PQRS quality measures and their average beneficiary risk score is in the top 25 percent of all beneficiary risk scores.