PQRS AND MEANINGFUL USE: WHAT'S NEW FOR 2015

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Director Scientific Affairs

CAC-PIAC 2014

PQRS: WHERE WE ARE TODAY

- PQRS in 2014
  - Two components:
    - Incentive Payment
    - Payment Adjustment Avoidance

Incentive payment

- 2014 will be the final year for the PQRS incentive payment
  - Payment will be 0.5% of Medicare Part B FFS payments for the entire year
  - Multiple methods to qualify for the incentive payment
  - Significant change in requirements to qualify for the incentive payment in 2014

QUALIFYING FOR INCENTIVE PAYMENT

- Methods to qualify:
  - Individual claims reporting
  - Registry Reporting
  - EHR reporting
  - Reporting through Qualified Clinical Data Registry (QCDR) (New for 2014)
  - Group Reporting Options

Individual Claims and registry Reporting Option

- Report on 9 PQRS measures and for each measure report on at least 50% of eligible patients
- The 9 measures should represent at least 3 of the 6 National Quality Strategy (NQS) domains
- If 9 measures are not available for your specialty, submit the maximum number of measures (1-8) that are available
- If you cannot represent 3 of the 6 NQS domains represent as many as possible

National Quality Strategy (NQS) Domains

- Patient and Family Engagement
- Patient Safety
- Communication and Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Processes/Effectiveness

Measure Applicability Validation (MAV) Process

- If less than 9 quality measures are available for an eligible provider to report (because of their specialty area of practice), then they can report 1-8 measures and if the available measures do not represent at least 3 of the 6 NQS domains, they can cover less than 3 of the domains. If either or both of these occur, then the eligible provider will be subject to the Measure Applicability Validation (MAV) process. Essentially, using the MAV process CMS reviews to make sure that the eligible provider could not have submitted more measures (if less than 9) and that they could not have covered more NQS domains (if less than 3).

Payment Adjustment Avoidance(to avoid the 2% reduction in 2016)

Meet the requirements for receiving the incentive payment,

OR

Report at least 3 measures, OR,
If less than 3 measures apply to the eligible professional, report 1-2 measures*; AND
Report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.

Measures with a 0 percent performance rate will not be counted.

PQRS in 2015

- No more incentive payments so participation is required to avoid the 2017 payment reduction (2% of all Medicare Part B FFS payments)
- All eligible professionals who do not meet the criteria for satisfactory reporting or satisfactory participation for the 2017 PQRS payment adjustment will be subject to the 2017 PQRS payment adjustment with **no exceptions**
- The 2015 PQRS includes the following reporting mechanisms: claims; qualified registry; EHR (including direct EHR products and EHR data submission vendor products); the Group Practice Reporting Option (GPRO) web interface; certified survey vendors, for the CAHPS for PQRS survey measures; and the QCDR.
- The push is for registry and EHR reporting
- In the future it will become more and more difficult for providers to participate in PQRS without an EHR

Requirements: claims and registry reporting

- For the 12-month reporting period for the 2017 PQRS payment adjustment (which is 2015), report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the eligible professional sees at least 1 Medicare patient in a face-to-face encounter, the eligible professional will report on at least 1 measure contained in the cross-cutting measure set. If less than 9 measures apply to the eligible professional, the eligible professional would report up to 8 measure(s), AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.

Requirements: direct EHR product that is CEHRT or an EHR data submission vendor

- For the 12-month reporting period for the 2017 PQRS payment adjustment, report 9 measures covering at least 3 of the NQS domains. If an eligible professional's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional would be required to report all of the measures for which there is Medicare patient data. An eligible professional would be required to report on at least 1 measure for which there is Medicare patient data.

Requirements: measure group reporting

- For the 12-month reporting period for the 2017 PQRS payment adjustment, report at least 1 measures group AND report each measures group for at least 20 patients, the majority (11 patients) of which are required to be Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted.

Requirements: Qualified Clinical Data Registry (QCDR)

- For the 12-month reporting period for the 2017 PQRS payment adjustment, report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, AND report each measure for at least 50 percent of the eligible professional's patients. Of these measures, the eligible professional would report on at least 2 outcome measures, OR, if 2 outcomes measures are not available, report on at least 1 outcome measures and at least 1 of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety.

Claims Reporting: An In Depth Look

Measure # (Domain)	Measure Description	Status for CY 2015
20 (PS)	Perioperative Care: Timing of Prophylactic Antibiotic-Ordering Physician	**Deleted**
21 (PS)	**Perioperative Care: Selection of Prophylactic Antibiotic**	Retained but only reportable through claims and registry as Perioperative Care Measures Group has been removed
22 (PS)	**Perioperative Care: Discontinuation of Prophylactic Antibiotic**	Retained but only reportable through claims and registry as Perioperative Care Measures Group has been removed
46 (CCC)	*Medication Reconciliation	Retained but domain changed to Communication and Care Coordination (CCC); claims-based reporting retained
110 (C/PH)	*Preventive Care and Screening: Influenza Immunization	No change; claims, registry and EHR reporting mechanisms available
111 (C/PH)	*Pneumonia Vaccination Status for Older Adults	Retained but domain changed to C/PH; claims, registry and EHR reporting mechanisms available
128 (C/PH)	*Preventive Care and Screening: Body Mass Index (BMI) Screening and F/U	No change; claims, registry and EHR reporting mechanisms available
130 (PS)	*Documentation of Current Medications in Medical Record	No change; claims, registry and EHR reporting mechanisms available
131 (C/PH)	*Pain Assessment and Follow-Up	No change; claims and registry reporting mechanisms available
154 (PS)	Falls: Risk Assessment	No change; claims and registry reporting mechanisms available
155 (CCC)	Falls: Plan of Care	2014 Measure Set lists this measure in the CCC domain, not the PS domain; no change proposed for CY 2015; claims and registry reporting mechanisms available
163 (ECC)	**Diabetes Mellitus: Foot Exam**	No change: claims, registry and EHR reporting mechanisms available
226 (C/PH)	*Preventive Care and Screening: Tobacco Use: Screening and Cessation	No change; claims, registry and EHR reporting mechanisms available
245 (ECC)	Chronic Wound Care: Use of Wound Surface Culture Technique	**Deleted**
246 (ECC)	Chronic Wound Care: Use of Wet to Dry Dressings in Patients	**Deleted**
317 (C/PH)	*Preventive Care and Screening: Screening for High Blood Pressure and F/U documented	No change; claims, registry and EHR reporting mechanisms available

*indicates cross cutting measure

Available for 2015 Reporting by Claims

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110 (C/PH)	*Preventive Care and Screening: Influenza Immunization	No change; claims, registry and EHR reporting mechanisms available
111 (C/PH)	*Pneumonia Vaccination Status for Older Adults	Retained but domain changed to C/PH; claims, registry and EHR reporting mechanisms available
128 (C/PH)	*Preventive Care and Screening: Body Mass Index (BMI) Screening and F/U	No change; claims, registry and EHR reporting mechanisms available
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154 (PS)	Falls: Risk Assessment	No change; claims and registry reporting mechanisms available
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163 (ECC)	Diabetes Mellitus: Foot Exam	No change: claims, registry and EHR reporting mechanisms available
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Measure # (Domain)	Measure Description	Status for CY 2015
21 (PS)	Perioperative Care: Selection of Prophylactic Antibiotic	Retained but only reportable through claims and registry as Perioperative Care Measures Group has been removed
22 (PS)	Perioperative Care: Discontinuation of Prophylactic Antibiotic	Retained but only reportable through claims and registry as Perioperative Care Measures Group has been removed

Diabetes Measures Group for 2015 and Beyond

NQF/ PQRS	Measure Title and Description	Measure Developer
0059/001	**Diabetes: Hemoglobin A1c Poor Control**: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period	NCQA
0041/110	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	AMA-PCPI
0055/117	**Diabetes: Eye Exam**: Percentage of patients 18 through 75 years of age with a diagnosis of diabetes (type 1 and type 2) who had a retinal or dilated eye exam in the measurement period or a negative retinal or dilated eye exam (negative for retinopathy) in the year prior to the measurement period	NCQA
0062/119	**Diabetes: Medical Attention for Neuropathy:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period	NCQA
0056/163	**Diabetes: Foot Exam:** Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period	NCQA
0028/226	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	AMA-PCPI

Summary of Requirements for the 2017 PQRS Payment Adjustment: Individual Reporting Criteria for the Satisfactory Reporting of Quality Measures Data via Claims, Qualified Registry, and EHRs and Satisfactory Participation Criterion in QCDRs

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting/Satisfactory Participation Criteria
12-month (Jan 1–Dec 31, 2015)	Individual Measures	Claims	Report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the eligible professional sees at least 1 Medicare patient in a face-to-face encounter, the eligible professional will report on at least 1 measure contained in the proposed cross-cutting measure set specified in Table 52. If less than 9 measures apply to the eligible professional, the eligible professional would report up to 8 measure(s), AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.
12-month (Jan 1–Dec 31, 2015)	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the eligible professional sees at least 1 Medicare patient in a face-to-face encounter, the eligible professional will report on at least 1 measure contained in the proposed cross-cutting measure set specified in Table 52. If less than 9 measures apply to the eligible professional, the eligible professional would report up to 8 measure(s), AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting/Satisfactory Participation Criteria
12-month (Jan 1– Dec 31, 2015)	Individual Measures	Direct EHR Product or EHR Data Submission Vendor Product	Report 9 measures covering at least 3 of the NQS domains. If an eligible professional's direct EHR product or EHR data submission vendor product does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional would be required to report all of the measures for which there is Medicare patient data. An eligible professional would be required to report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1– Dec 31, 2015)	Measures Groups	Qualified Registry	Report at least 1 measures group AND report each measures group for at least 20 patients, the majority (11 patients) of which are required to be Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted.
12-month (Jan 1– Dec 31, 2015)	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR	Qualified Clinical Data Registry (QCDR)	Report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, AND report each measure for at least 50 percent of the eligible professional's patients. Of these measures, the eligible professional would report on at least 2 outcome measures, OR, if 2 outcomes measures are not available, report on at least 1 outcome measures and at least 1 of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety

Summary of Requirements for the 2017 PQRS Payment Adjustment: Group Practice Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1–Dec 31, 2015)	25-99 eligible professionals	Individual GPRO Measures in the GPRO Web Interface	GPRO Web Interface	Report on all measures included in the web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100 percent of assigned beneficiaries. In other words, we understand that, in some instances, the sampling methodology we provide will not be able to assign at least 248 patients on which a group practice may report, particularly those group practices on the smaller end of the range of 25–99 eligible professionals. If the group practice is assigned less than 248 Medicare beneficiaries, then the group practice must report on 100 percent of its assigned beneficiaries. A group practice must report on at least 1 measure for which there is Medicare patient data.

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1–Dec 31, 2015)	25-99 eligible professionals and100+ eligible professionals	Individual GPRO Measures in the GPRO Web Interface + CAHPS for PQRS	GPRO Web Interface + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor. In addition, the group practice must report on all measures included in the GPRO web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100 percent of assigned beneficiaries. A group practice will be required to report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31, 2015)	2-99 eligible professionals	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the NQS domains. Of these measures, if a group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice would report on at least 1 measure in the cross-cutting measure set specified in Table 52. If less than 9 measures covering at least 3 NQS domains apply to the group practice, the group practice would report up to 8 measures covering 1–3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the group's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1– Dec 31, 2015)	2-99 eligible professionals and 100+ eligible professionals	Individual Measures + CAHPS for PQRS	Qualified Registry + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 of the NQS domains using the qualified registry. If less than 6 measures apply to the group practice, the group practice must report up to 5 measures. Of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, if any eligible professional in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice must report on at least 1 measure in the cross-cutting measure set specified in Table 52.
12-month (Jan 1– Dec 31, 2015)	2-99 eligible professionals	Individual Measures	Direct EHR Product or EHR Data Submission Vendor Product	Report 9 measures covering at least 3 domains. If the group practice's direct EHR product or EHR data submission vendor product does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1– Dec 31, 2015)	2-99 eligible professionals and 100+ eligible professionals	Individual Measures + CAHPS for PQRS	Direct EHR Product or EHR Data Submission Vendor Product + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 of the NQS domains using the direct EHR product or EHR data submission vendor product. If less than 6 measures apply to the group practice, the group practice must report up to 5 measures. Of the additional 6 measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, a group practice would be required to report on at least 1 measure for which there is Medicare patient data.

Meaningful Use 2015

- 2014 is the last year to attest for MU and be eligible for any incentive payments
- 2014 is the first year that some eligible providers were scheduled to begin Stage 2 of MU (see more on Flexibility Rule)
- Penalties for not attesting to MU begin in 2015 but are based on participation in 2013 (mostly)
- All eligible providers attesting to MU in 2014 only needed to attest for 90 days

Medicare Eligible Professional Stages Timeline

This is a timeline of participation and payments by stage of meaningful use for Medicare eligible professionals:

Maximum Payment by Start Year	2011	2012	2013	2014	2015	2016
2011	1	1	1	2	2	3
$43,720	$18,000	$12,000	$7,840 Reduction ($160)	$3,920 Reduction ($80)	$1,960 Reduction ($40)	
2012		1	1	2	2	3
$43,480		$18,000	$11,760 Reduction ($240)	$7,840 Reduction ($160)	$3,920 Reduction ($80)	$1,960 Reduction ($40)
2013			1	1	2	2
$38,220			$14,700 Reduction ($80)	$11,760 Reduction ($240)	$7,840 Reduction ($160)	$3,920 Reduction ($80)
2014				1	1	2
$23,520				$11,760 Reduction ($240)	$7,840 Reduction ($160)	$3,920 Reduction ($80)

Note: Medicare EHR incentive payments made are subject to the mandatory reductions in federal spending known as sequestration. This 2% reduction will be applied to any Medicare EHR incentive payment for a reporting period that ends on or after April 1, 2013. If the final day of the reporting period occurs before April 1, 2013, those incentive payments will not be subject to the reduction.

Flexibility in Compliance with 2014 CEHRT Requirements

- CMS and ONC recognize that many health care providers have been unable to roll out 2014 Edition CEHRT in compliance with meaningful use requirements because EHR vendors were unable to timely develop EHR products that met the 2014 Edition of the EHR certification criteria. CMS and ONC therefore finalized the May 2014 proposal that eligible professionals ("EPs") **that are not able to fully implement the 2014 Edition CEHRT as a consequence of EHR product availability delays will be provided flexibility in complying with their meaningful use requirements.**

Providers (that attest to a delay) will have three options when it comes to their 2014 meaningful use attestations:

- **Option 1: 2011 Edition CEHRT Only.** EPs using only 2011 Edition CEHRT during the 2014 EHR reporting period must meet the meaningful use objectives and measures for Stage 1 that were applicable during the 2013 payment year, regardless of their current meaningful use stage.

- **Option 2: Combination of 2011 and 2014 Edition CEHRT.** EPs using a combination of 2011 Edition CEHRT and 2014 Edition CEHRT during the 2014 EHR reporting period may choose to meet the 2013 Stage 1 or 2014 Stage 1 objectives and measures. Alternatively, if providers are scheduled to begin Stage 2 in 2014, they could choose to meet the Stage 2 objectives and measures.

- **Option 3: 2014 Edition CEHRT Only.** EPs that are scheduled to begin Stage 2 for the 2014 EHR reporting period, but are unable to fully implement all the functions of their 2014 Edition CEHRT required for Stage 2 objectives and measures, may attest to the 2014 Stage 1 objectives and measures for the 2014 reporting period.

CLINICAL QUALITY MEASURES REPORTING

- Pay attention to the CQM reporting requirement—it depends on what reporting option you choose:
  - Eligible professionals demonstrating 2013 Definition Stage 1 of meaningful use using 2011 CEHRT would use the list of Clinical Quality Measures (CQMs) finalized in 2011 to report:
    - 3 required core measures or 3 alternate core, and
    - 3 additional measures (out of 44)
  - Eligible professionals demonstrating 2014 Definition of Stage 1(or Stage 2) of meaningful use using 2014 CEHRT would use 2014 clinical quality measures (CQMs):
    - Need to report 9 measures (out of 64)
    - Need to represent 3 of 6 National Quality Strategy domains.

The above options are only available to providers that attest they are *"not able to fully implement"* 2014 Edition CEHRT as a result of *"delays in 2014 Edition CEHRT availability."* Recognizing the need for clarity regarding these two standards, CMS and ONC provide the following guidance in the Final Rule:

- **"not able to fully implement":** CMS and ONC explain that they intend the options described above to be broadly available to providers. The agencies therefore do not establish a specific definition for "not able to fully implement," but instead offer four non-exclusive scenarios, as examples, that would ***not*** constitute inability to fully implement 2014 Edition CEHRT: (i) financial issues, such as costs associated with implementing, upgrading, installing, testing or similar financial issues; (ii) with a limited exception related to technical requirements of the summary of care document measure, issues related to the meaningful use objectives and measures; (iii) personnel matters, including staff changes and turnover; and (iv) provider inaction or delay.

- **"delays in 2014 Edition CEHRT availability":** CMS and ONC also clarify that "delays in 2014 Edition CEHRT availability" refers specifically to one or more delays related to the development, certification, testing and release of an EHR product (including updates, software patches and other modifications required by the provider after rollout of the EHR product) by the EHR vendor or developer that resulted in an inability of the provider to fully implement 2014 Edition CEHRT for an EHR reporting period in 2014.

SECURITY RISK ANALYSIS

New CMS Guidance for When to Complete a Security Risk Analysis

- A security risk analysis needs to be conducted or reviewed during each program year for Stage 1 and Stage 2. These steps may be completed outside **OR** during the EHR reporting period timeframe, but must take place no earlier than the start of the reporting year and no later than the end of the reporting year.

- For example, an eligible professional who is reporting for a 90-day EHR reporting period in 2014 may complete the appropriate security risk analysis requirements outside of this 90-day period as long as it is completed between January 1st and December 31st in 2014.

Hardship Exception Applications to Avoid the 2015 Medicare Payment Adjustment Due November 30, 2014

- CMS reopened the submission period for hardship exception applications for eligible professionals and eligible hospitals to avoid the 2015 Medicare payment adjustments for not demonstrating meaningful use of Certified Electronic Health Record Technology (CEHRT). The new deadline is November 30, 2014. Previously, the hardship exception application deadline was July 1, 2014 for eligible professionals.

This reopened hardship exception application submission period is for eligible professionals and eligible hospitals that:

- Have been unable to fully implement 2014 Edition CEHRT due to delays in 2014 Edition CEHRT availability; **AND**

- Eligible professionals who were unable to attest by October 1, 2014 using the flexibility options provided in the CMS 2014 CEHRT Flexibility Rule.

Meaningful Use for 2015

- The flexibility rule extended Stage 2 through 2016, so right now the earliest anyone will have to report Stage 3 is 2017

- Beginning in CY 2015, EPs are not required to ensure that their CEHRT products are recertified to the most recent version of the electronic specifications for the CQMs. Although CMS is not requiring recertification, EPs must still report the most recent version of the electronic specifications for the CQMs.

- For 2015, all eligible providers will be required to use a 2014 CEHRT and the reporting period will be the entire year (unless 2015 is your first year attesting to MU)

Value Based Payment Modifier (VM)

- Section 1848(p) of the Act requires that we establish a value-based payment modifier (VM) and apply it to specific physicians and groups of physicians the Secretary determines appropriate starting January 1, 2015, and to all physicians and groups of physicians by January 1, 2017.
- Section 1848(p)(4)(C) of the Act requires the VM to be **budget neutral**.

A focus on measurement and alignment

- Measures for the VM should consistently reflect differences in performance among groups or solo practitioners, reflect the diversity of services furnished, and be consistent with the National and CMS Quality Strategies and other CMS quality initiatives, including the PQRS, the Shared Savings Program, and the Medicare EHR Incentive Program.

A FOCUS ON PHYSICIAN AND ELIGIBLE PROFESSIONAL CHOICE

- Physicians and other non-physician eligible professionals should be able to choose the level (individual or group) at which their quality performance will be assessed, reflecting eligible professionals' choice over their practice configurations. The choice of level should align with the requirements of other physician quality reporting programs.

A FOCUS ON SHARED ACCOUNTABILITY

- The VM can facilitate shared accountability by assessing performance at the group level and by focusing on the total costs of care, not just the costs of care furnished by an individual professional.

A FOCUS ON ACTIONABLE INFORMATION

- The Quality and Resource Use Reports (QRURs) should provide meaningful and actionable information to help groups and solo practitioners identify clinical, efficiency and effectiveness areas where they are doing well, as well as areas in which performance could be improved by providing groups and solo practitioners with QRURs on the quality and cost of care they furnish to their patients.

A FOCUS ON A GRADUAL IMPLEMENTATION

- The VM should focus initially on identifying high and low performing groups and solo practitioners. As we gain more experience with physician measurement tools and methodologies, we can broaden the scope of measures assessed, refine physician peer groups, create finer payment distinctions, and provide greater payment incentives for high performance.

Gradual Implementation

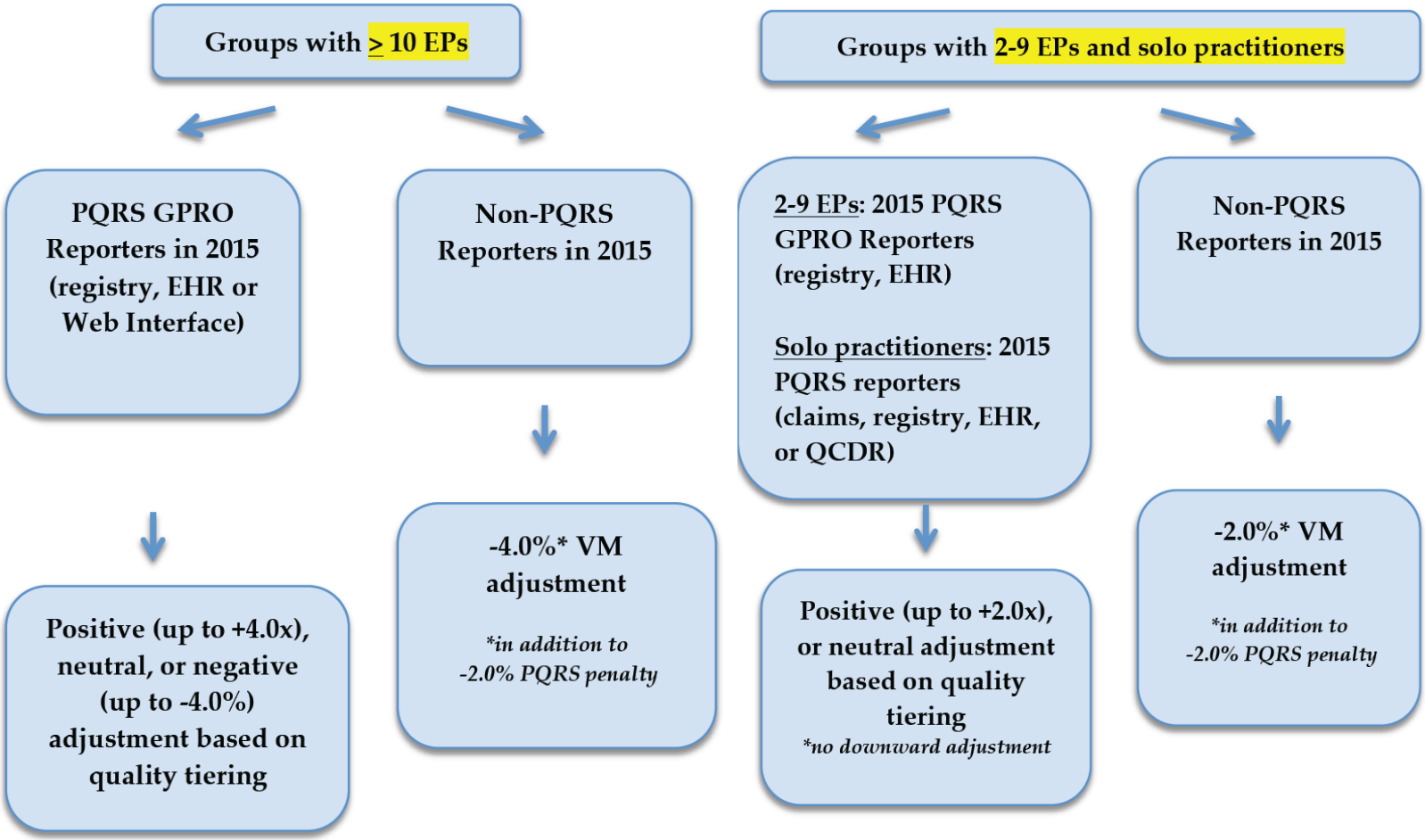
- In the 2013 PFS final rule, VM scheduled to be applied to physicians in groups of **100 or more** starting January 1, 2015.
- In the 2014 PFS final rule, VM scheduled to be applied to physicians in **groups of 10 or more** starting January 1, 2016.
- In the 2015 PFS final rule, VM to all physicians in **groups with two or more eligible professionals and to solo practitioners** starting in CY 2017.

Eligible Professional/Physician Group Size Distribution (2013 claims)

Group Size	Number of Groups (TINs)*	Eligible Professionals (EPs)	Number of Physicians	Number of Nonphysician EPs	Percent of Physicians	Percent of Nonphysician EPs
100+ EPs	1,345	404,738	297,175	107,563	33%	30%
50-99EPs	1,753	119,979	81,679	38,300	9%	11%
25-49 EPs	3,926	134,038	90,141	43,897	10%	12%
20-24 EPs	1,957	42,733	29,112	13,621	3%	4%
10-19 EPs	8,697	117,164	78,893	38,271	9%	11%
2-9 EPs	69,455	244,800	171,627	73,173	19%	20
1 EP	205,084	205,084	159,770	45,314	18%	13
Total	292,217	1,268,536	908,397	360,139	100%	100%

*The number of groups (TINs) include TINs that have one or more EPs participating in the Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care Initiative.

Application of the 2017 Value-Based Payment Modifier



Calculation of the 2017 Value Modifier Using the Quality-Tiering Approach

Groups with > 10 EPs			
Cost/Quality	Low Quality	Ave Quality	High Quality
Low Cost	0.0%	+2.0x*	+4.0x*
Average Cost	-2.0%	0.0%	+2.0x*
High Cost	-4.0%	-2.0%	0.0%

Groups with 2-9 EPs and solo practitioners			
Cost/Quality	Low Quality	Ave Quality	High Quality
Low Cost	0.0%	+1.0x*	+2.0x*
Average Cost	0.0%	0.0%	+1.0x*
High Cost	0.0%	0.0%	0.0%

** Groups eligible for an additional +1.0x if average beneficiary risk score is in the top 25% of all beneficiary risk scores, where 'x' represents the upward payment adjustment factor. The upward payment adjustment factor will be determined after the performance period has ended based on the aggregate amount of downward payment adjustments.*

QUESTIONS?

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