CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Physician Update:
What's New for 2014

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Region 9
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Agenda

- Brief Update on 2014 Physician Fee Schedule:
  - Physician Quality Reporting System (PQRS)
  - Value-Based Payment Modifier (VM)
  - ePrescribing (eRx)
  - Electronic Health Record (EHR) Incentive Programs
  - ICD-10
- A little crystal ball gazing
- Focus on what has changed in 2014, avoiding payment adjustments, and receiving incentives
- Q&A

Physician Quality Reporting System and the Value Modifier

PQRS Overview

- Reporting program began in 2007
- Eligible Professionals (EPs) or group practices who satisfactorily report quality data earn an 0.5% incentive payment for CY 2012 - 2014
- Additional 0.5% for the Maintenance of Certification Program Incentive, if applicable
- 2014 – Last year for incentive
- 2015 – Payment adjustment of -1.5% based on CY2013 participation
- 2016 - Payment adjustment of -2.0% based on CY2014 participation

Value-Based Payment Modifier (VM) Overview

- VM assesses both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule
- Begin phase-in of VM in 2015, phase-in complete by 2017
  - 2015 - VM applies to physician payment for groups with ≥100 EPs
  - 2016 - VM applies to physician payment for groups with ≥10 EPs
  - 2017 – VM applied to all, or nearly all, physician payments
- Based on participation in PQRS

Value Modifier Policies for 2015 & 2016

Value Modifier Components	2015 Finalized Policies	2016 Finalized Policies
Performance Year	2013	2014
Group Size	100+	10+
Available Quality Reporting Mechanisms	GPRO-Web Interface, CMS Qualified Registries, Administrative Claims	GPRO-Web Interface, CMS Qualified Registries, EHRs, and 50% of EPs reporting individually
Outcome Measures NOTE: The performance on the outcome measures and measures reported through the PQRS reporting mechanisms will be used to calculate a quality composite score for the group for the VM.	All Cause Readmission Composite of Acute Prevention Quality Indicators: (bacterial pneumonia, urinary tract infection, dehydration) Composite of Chronic Prevention Quality Indicators: (chronic obstructive pulmonary disease (COPD), heart failure, diabetes)	Same as 2015
Patient Experience Care Measures	N/A	PQRS CAHPS: option for groups of 25+ EPs

Value Modifier Policies for 2015 & 2016

Value Modifier Components	2015 Finalized Policies	2016 Finalized Policies
Cost Measures	**Total per capita costs measure (annual payment standardized and risk-adjusted Part A and Part B costs)** **Total per capita costs for beneficiaries with four chronic conditions: COPD, Heart Failure, Coronary Artery Disease, Diabetes**	**Same as 2015 and:** **Medicare Spending Per Beneficiary measure (includes Part A and B costs during the 3 days before and 30 days after an inpatient hospitalization)**
Benchmarks	**Group Comparison**	**Specialty Adjusted Group Cost**
Quality Tiering	**Optional**	**Mandatory** **Groups of 10-99 EPs receive only the upward (or neutral) adjustment, no downward adjustment. Groups of 100+ both the upward and downward adjustment apply (or neutral adjustment).**
Payment at Risk	-1.0%	-2.0%

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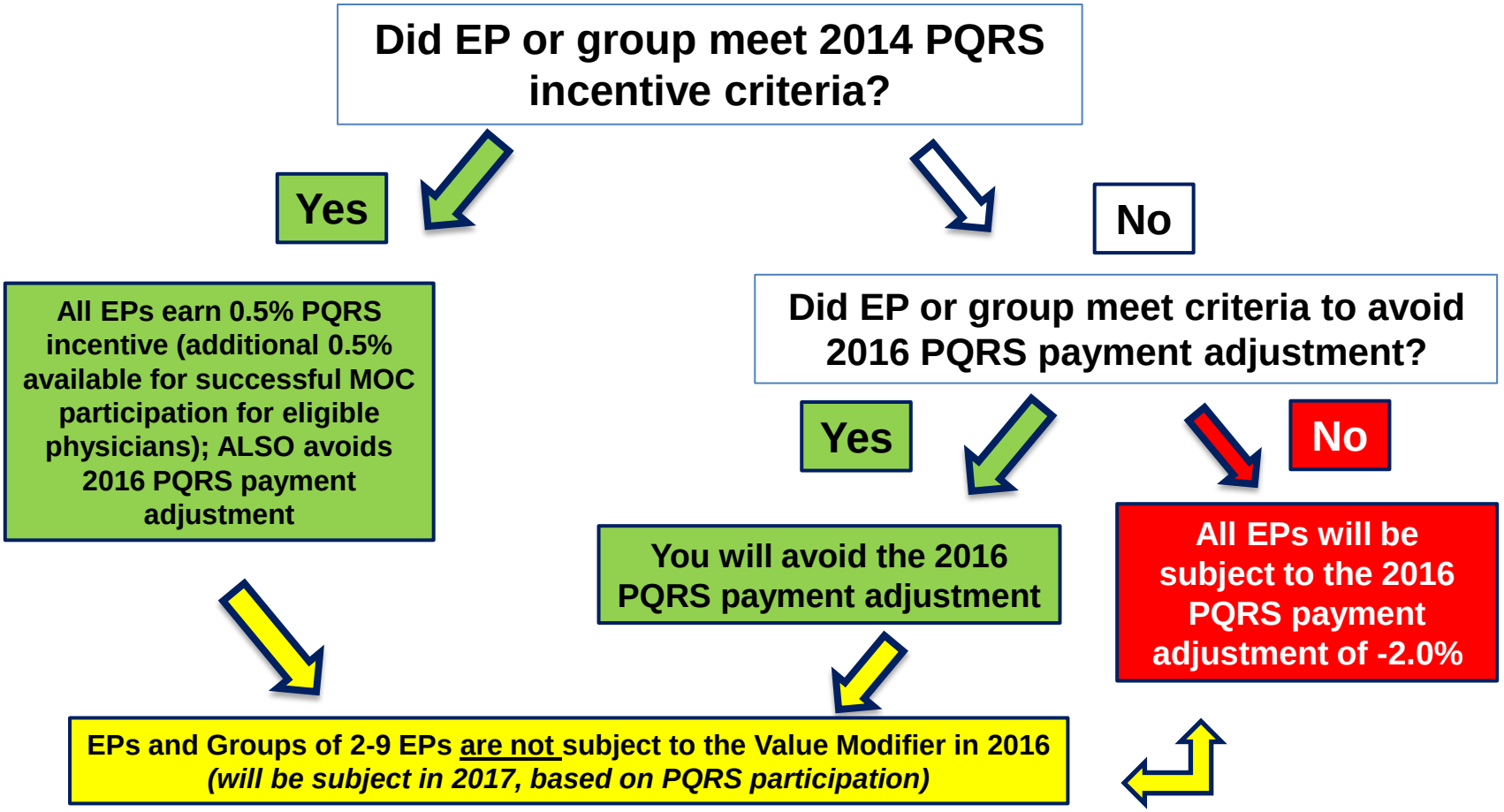
How Will I Participate in PQRS?

- **Will you participate as an individual or a group?**
  - **If a group: how many EPs are in your group?**
- **Individuals can report using 5 methods:**
  1. **Claims (Individual measures)**
  2. **Qualified Registry (Individual measures or measures groups)**
  3. **Direct EHR product that is CEHRT**
  4. **EHR data submission vendor that is CEHRT (Individual Measures)**
  5. **Qualified Clinical Data Registry (Measures selected by QCDR)**

PQRS Participation in 2014 for Individuals and Groups of 2-9 EPs



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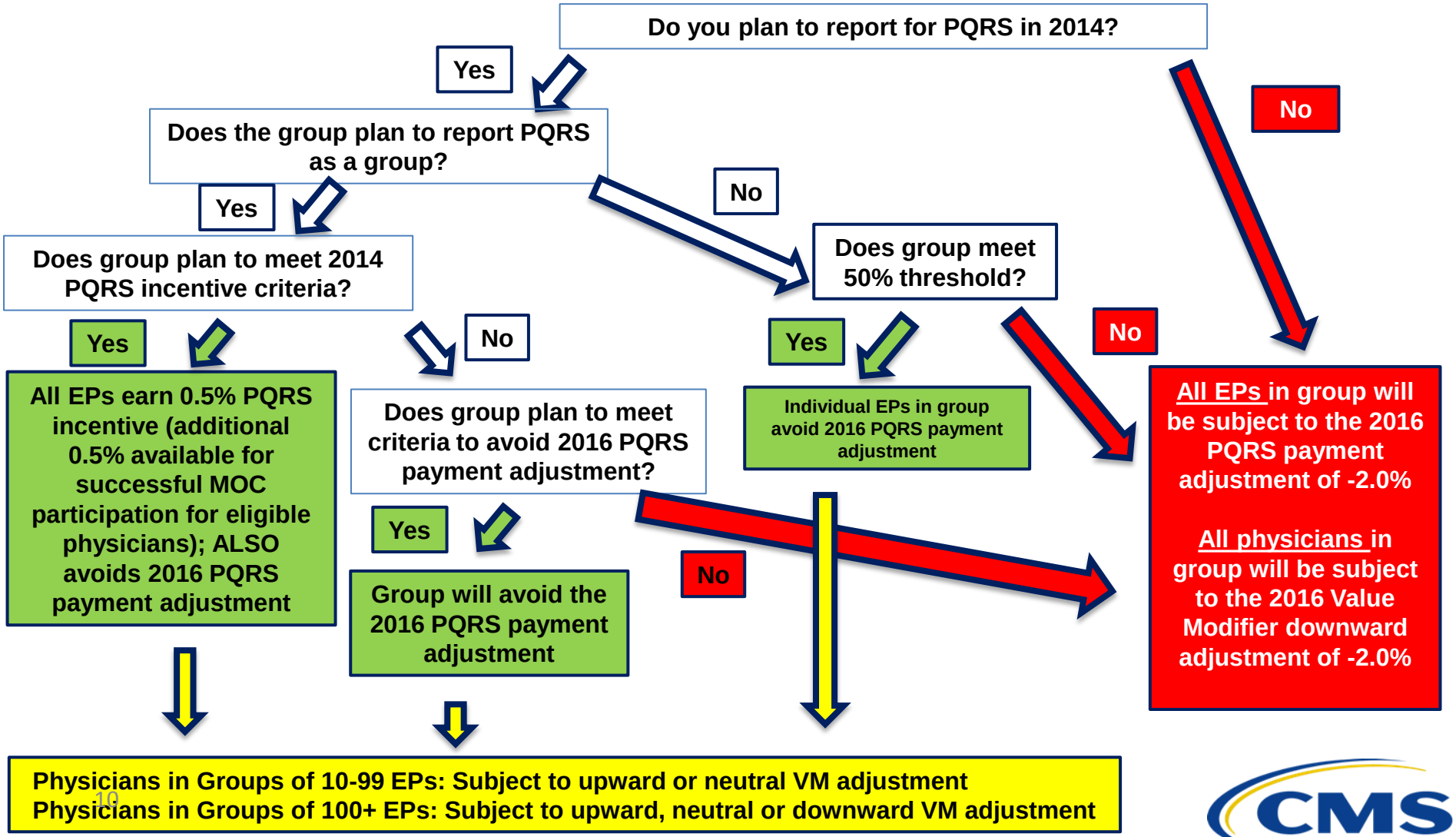
PQRS Participation in 2014 for Individuals and Groups of ≥10 EPs



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How Can I Access My Report and Drill-Downs?

1. Navigate to the Portal	• Go to https://portal.cms.gov
2. Login to the Portal	• Select Login to CMS Secure Portal • Accept the Terms and Conditions and enter your IACS User ID and Password to login.
3. Enter the Portal	• Click the PV-PQRS tab, and select the QRUR-Reports option.

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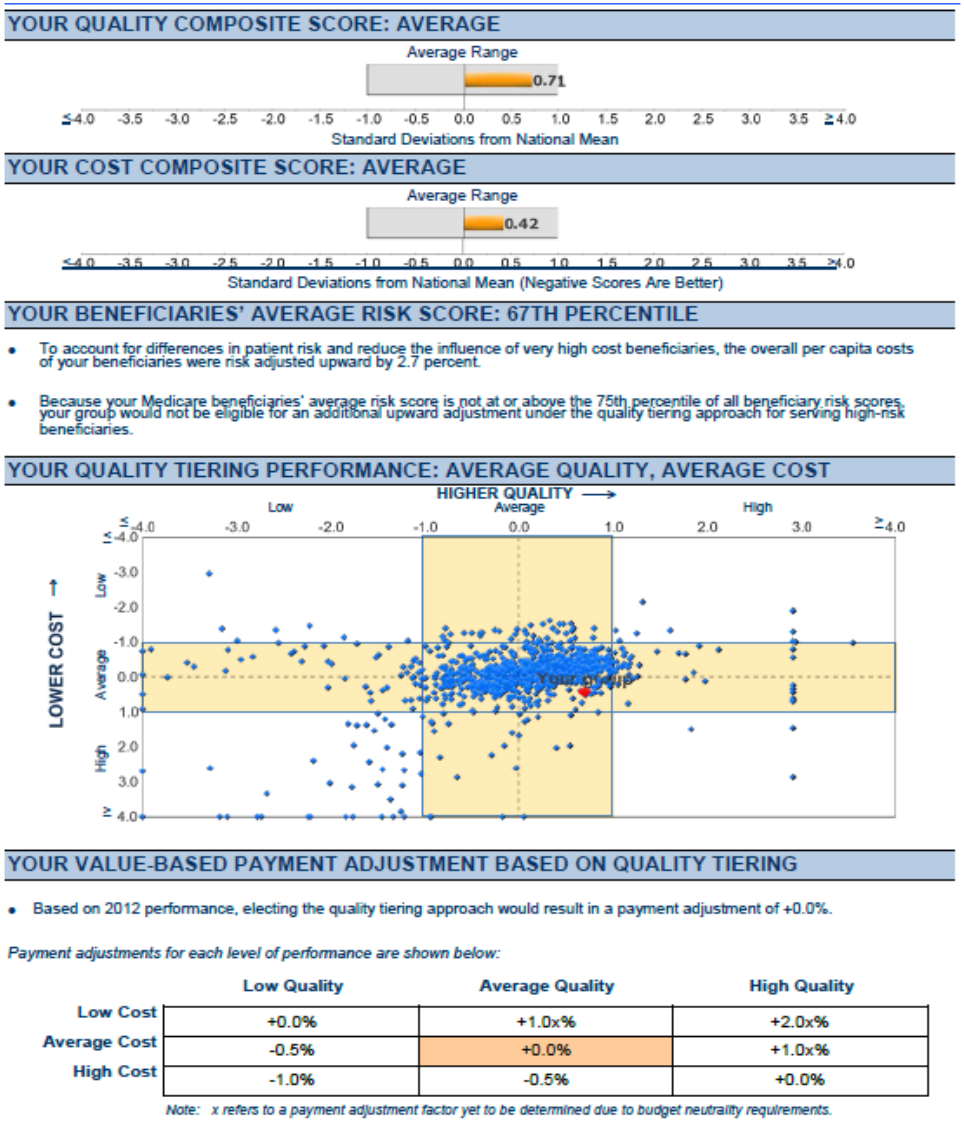
What Information Is Included on the Performance Highlights Page?

1. **Your Quality Composite Score**
2. **Your Cost Composite Score**
3. **Your Beneficiaries' Average Risk Score**
4. **Your Quality Tiering Performance Graph**
5. **Your Payment Adjustment Based on Quality Tiering**



YOUR QUALITY COMPOSITE SCORE: AVERAGE

Average Range

0.71

≤-4.0 -3.5 -3.0 -2.5 -2.0 -1.5 -1.0 -0.5 0.0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 ≥4.0

Standard Deviations from National Mean

YOUR COST COMPOSITE SCORE: AVERAGE

Average Range

0.42

≤-4.0 -3.5 -3.0 -2.5 -2.0 -1.5 -1.0 -0.5 0.0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 ≥4.0

Standard Deviations from National Mean (Negative Scores Are Better)

YOUR BENEFICIARIES' AVERAGE RISK SCORE: 67TH PERCENTILE

- To account for differences in patient risk and reduce the influence of very high cost beneficiaries, the overall per capita costs of your beneficiaries were risk adjusted upward by 2.7 percent.
- Because your Medicare beneficiaries' average risk score is not at or above the 75th percentile of all beneficiary risk scores, your group would not be eligible for an additional upward adjustment under the quality tiering approach for serving high-risk beneficiaries.

YOUR QUALITY TIERING PERFORMANCE: AVERAGE QUALITY, AVERAGE COST

HIGHER QUALITY ⟶

Low Average High

≤-4.0 -3.0 -2.0 -1.0 0.0 1.0 2.0 3.0 ≥4.0

LOWER COST ↑

Low Average High

≤-4.0 -3.0 -2.0 -1.0 0.0 1.0 2.0 3.0 ≥4.0

Your Group

YOUR VALUE-BASED PAYMENT ADJUSTMENT BASED ON QUALITY TIERING

- Based on 2012 performance, electing the quality tiering approach would result in a payment adjustment of +0.0%.

Payment adjustments for each level of performance are shown below:

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x%	+2.0x%
Average Cost	-0.5%	+0.0%	+1.0x%
High Cost	-1.0%	-0.5%	+0.0%

Note: x refers to a payment adjustment factor yet to be determined due to budget neutrality requirements.

(payment adjustments in example based on 2015 VM implementation)

PQRS/VM 2014 Important Dates

Date	Program	Milestone
January 1, 2014	PQRS/Value Modifier	• Reporting period begins
January 31, 2014	PQRS	• Deadline for self-nomination statement for Qualified Clinical Data Registries (QCDRs) (Qnetsupport@sdps.org) • Deadline for self-nomination for Maintenance of Certification (PQRS_Vetting@mathematica-mpr.com)
February 28, 2014	PQRS	• Last day to submit 2013 PQRS data through some reporting methods (deadline for submission of PQRS data varies by reporting method, but all methods require data to be submitted by end of first quarter in 2014) • Last day to submit Part B charges to be included in calculation of 2013 PQRS and eRx incentive payments
March 31, 2014	PQRS	• Deadline for submission of measures information for QCDRs

ePrescribing

eRx Overview

- **What is the Medicare eRx Incentive Program?**
  - **Established by MIPPA in 2009 to encourage EPs to adopt electronic prescribing systems**
- **2014 eRx Incentive Program**
  - **2% payment adjustment**

How to Avoid 2014 eRx Payment Adjustment

Not subject to adjustment if you:

- **Are a successful electronic prescriber; For individuals:**
  - **Reported eRx measure via claims for ≥25 unique eRx events for eligible encounters between January 1 and December 31, 2012**
  - **Reported eRx measure via claims for ≥10 unique eRx events for eligible encounters between Jan. 1 and June 30, 2013 and processed by July 26, 2013**
- **Are NOT a physician, nurse practitioner, or physician assistant**
- **Submitted one of three G codes at least once on eligible claim prior to June 30, 2013: G8642 (rural area), G8643 (insufficient pharmacies), or G8644 (no prescribing privileges)**
- **File <100 claims containing an encounter code in the eRx measure's denominator with dates of service between January 1 and June 30, 2013**
- **Have <10% of your Medicare Part B PFS total allowed charges comprised of codes in the measure's denominator**
- **Report a significant hardship code and we determine that hardship applies**

Avoiding the 2014 eRx Payment Adjustment (-2.0% of MFPS)

Practice Size	Report the eRx measure's numerator code at least:	
	6-month period (Jan 1- June 30, 2013) OR	12-month period (Jan 1 – Dec 31, 2012)
Individual EPs	10 times	25 times
2-24 EPs (new in 2013)	75 times	NA
25-99 EPs	625 times	625 times
100+ EPs	2500 times	2500 times

EHR Incentive Programs

What is Your Meaningful Use Path?

For Medicare EPs:

Maximum Payment by Start Year	Annual Incentive Payment by Stage of Meaningful Use					
	2011	2012	2013	2014	2015	2016
2011	1	1	1	2	2	3
$44,000	$18,000	$12,000	$8,000	$4,000	$2,000	
2012		1	1	2	2	3
$44,000		$18,000	$12,000	$8,000	$4,000	$2,000
2013			1	1	2	2
$39,000			$15,000	$12,000	$8,000	$4,000
2014				1	1	2
$24,000				$12,000	$8,000	$4,000

What is Your Meaningful Use Path?

For Medicaid EPs:

Annual Incentive Payment by Stage of Meaningful Use					
YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6
(AIU)	1	1	2	2	3
$21,250	$8,500	$8,500	$8,500	$8,500	$8,500

Maximum incentive amount is $63,750. Payments are made over 6 years and do not have to be consecutive.

*2016 is the last year that Medicaid EPs can begin participation in the program.

Meaningful Use:
Changes from Stage 1 to Stage 2

Stage 1	Stage 2
Eligible Professionals 15 core objectives 5 of 10 menu objectives 20 total objectives	**Eligible Professionals** **17** core objectives **3 of 6** menu objectives 20 total objectives
Eligible Hospitals & CAHs 14 core objectives 5 of 10 menu objectives 19 total objectives	**Eligible Hospitals & CAHs** **16** core objectives **3 of 6** menu objectives 19 total objectives

Payment Adjustments for Providers Eligible for Both EHR Programs

If you are eligible to participate in both Medicare and Medicaid EHR Incentive Programs:

- **You MUST demonstrate meaningful use according to established timelines to avoid payment adjustments**
- **You may demonstrate meaningful use under either Medicare or Medicaid.**

Note: Congress mandated that an EP must be a meaningful user in order to avoid the payment adjustment; therefore receiving a Medicaid EHR incentive payment for adopting, implementing, or upgrading your certified EHR Technology would not exempt you from the payment adjustments.

EP EHR Payment Adjustments

% Adjustment shown below assumes less than 75% of EPs are meaningful users for CY 2018 and subsequent years

	2015	2016	2017	2018	2019	2020+
EP is not subject to the payment adjustment for e-Rx in 2014	99%	98%	97%	96%	95%	95%
EP is subject to the payment adjustment for e-Rx in 2014	98%	98%	97%	96%	95%	95%

% Adjustment shown below assumes more than 75% of EPs are meaningful users for CY 2018 and subsequent years

	2015	2016	2017	2018	2019	2020+
EP is not subject to the payment adjustment for e-Rx in 2014	99%	98%	97%	97%	97%	97%
EP is subject to the payment adjustment for e-Rx in 2014	98%	98%	97%	97%	97%	97%

EP EHR Payment Adjustments, *cont.*

Payment adjustments are based on prior years' reporting periods. The length of the reporting period depends upon the first year of participation.

For example, if an EP first demonstrated meaningful use in 2011 or 2012:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on Full Year EHR Reporting Period	2013	2014*	2015	2016	2017	2018

*** Special 3 month EHR reporting period**

For an EP who demonstrates meaningful use in 2013 for the first time:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on 90 day EHR Reporting Period	2013					
Based on Full Year EHR Reporting Period		2014*	2015	2016	2017	2018

To Avoid Payment Adjustments:
EPs must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

EP EHR Reporting Period, *cont.*

EP who demonstrates meaningful use in 2014 for the first time:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on 90 day EHR Reporting Period	2014*	2014				
Based on Full Year EHR Reporting Period			2015	2016	2017	2018

**** In order to avoid the 2015 payment adjustment the EP must attest no later than October 1, 2014, which means they must begin their 90 day EHR reporting period no later than July 1, 2014.***

EHR Hardship Exceptions

EPs can apply for hardship exceptions in the following categories:

1. **Infrastructure**
   EPs must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband).

2. **New EPs**
   Newly practicing EPs who would not have had time to become meaningful users can apply for a 2-year limited exception to payment adjustments.

3. **Unforeseen Circumstances**
   Examples may include a natural disaster or other unforeseeable barrier.

4. **EPs must demonstrate that they meet the following criteria:**

- Lack of face-to-face or telemedicine interaction with patients
- Lack of follow-up need with patients

5. **EPs who practice at multiple locations must demonstrate that they:**

- Lack of control over availability of CEHRT for more than 50% of patient encounters

EHR Hardship Exceptions

EPs whose primary specialties are anesthesiology, radiology or pathology:

- **As of July 1st of the year preceding the payment adjustment year, EPs in these specialties will receive a hardship exception based on the 4th criteria for EPs:**

  EPs must demonstrate that they meet the following criteria:
  - **Lack of face-to-face or telemedicine interaction with patients**
  - **Lack of follow-up need with patients**

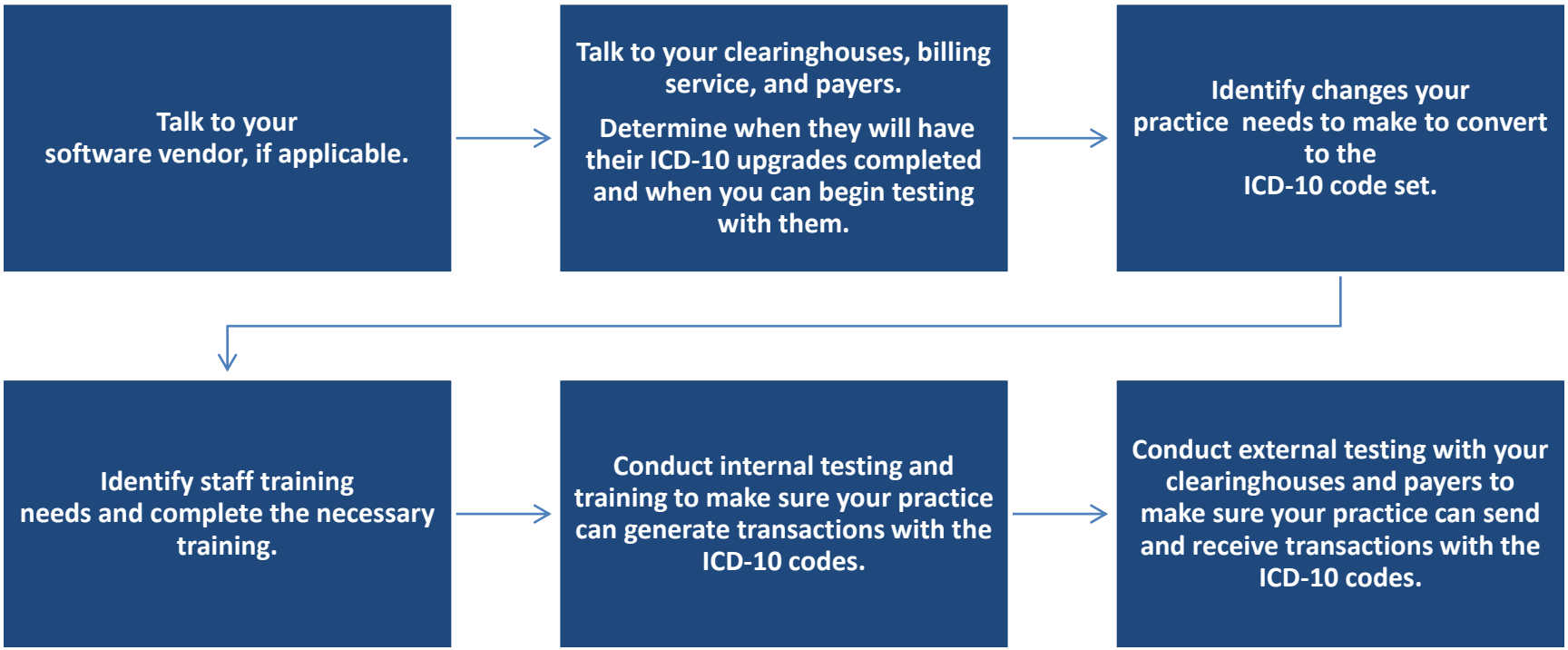
EHR Milestone Dates

Date	Milestone
~~**February 28, 2014**~~ **March 31, 2014**	• Last day to attest to meaningful use for the 2013 Medicare EHR incentive
June 30, 2014	• Last day to apply for exemption to avoid 2015 Medicare MU payment adjustment
July 1, 2014	• Last day to start 90-day reporting period to earn 2014 MU incentive and avoid the 2015 & 2016 Medicare MU payment adjustments

Crystal Ball Gazing

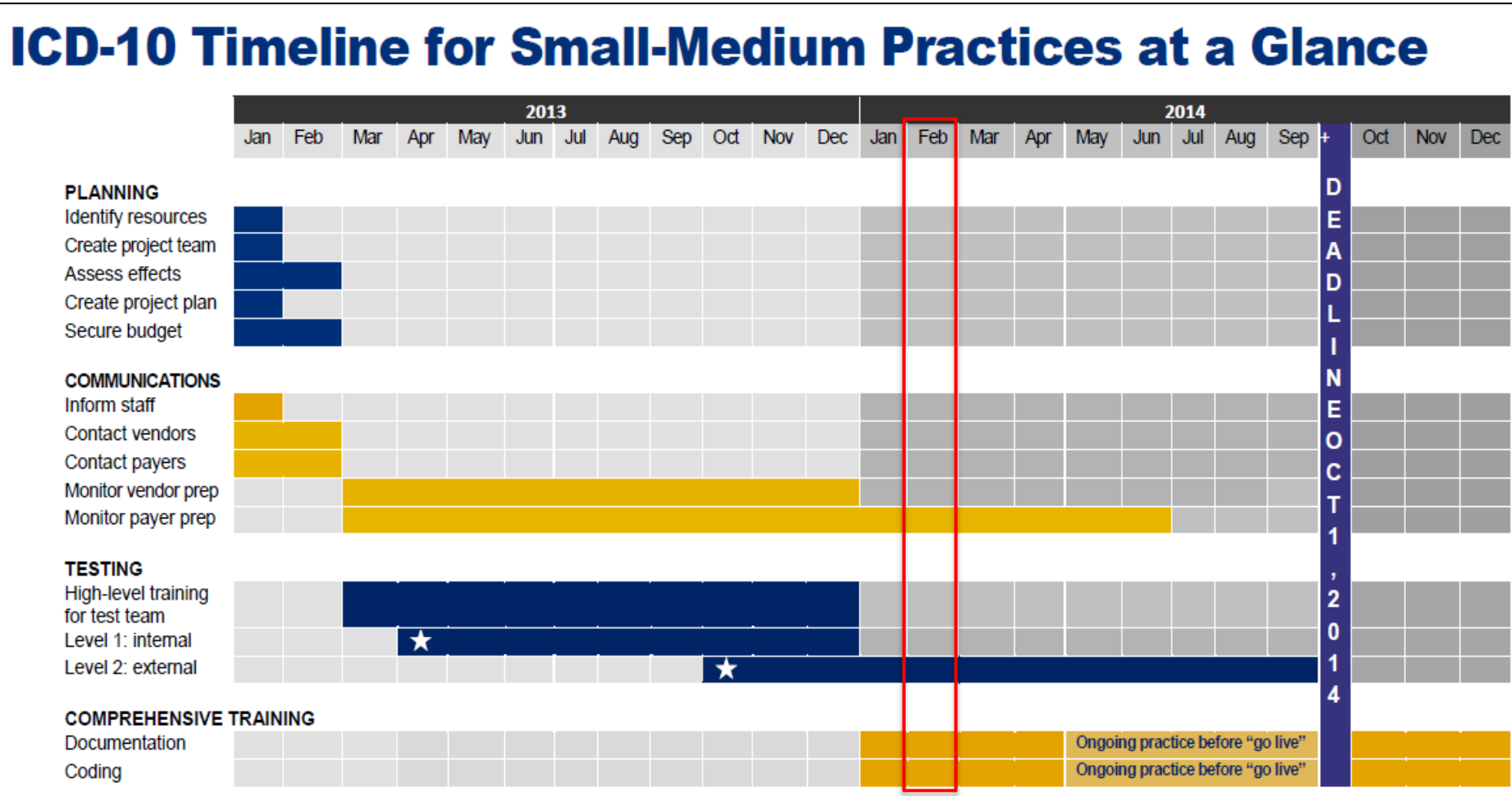
ICD-10 Implementation

What Should You Do to Prepare?



Helpful Links:
http://www.himss.org/library/icd-10/playbook?navItemNumber=13480
https://implementicd10.noblis.org/wp-uploads/2013/03/VendorChecklist_smallmed.pdf

Where Should You Be?



Resources

CMS website:

www.cms.gov/icd10

- **Fact sheets**
- **FAQs**
- **Implementation guides**
- **Timelines**
- **Checklists**

Take Home

- PQRS, eRx, EHR, VM are separate programs (for now)
- Each has separate criteria for
  - Receiving incentive
  - Avoiding payment adjustment
  - Pay attention to both!
- Take steps now to avoid payment adjustments and maximize incentive payments
- ICD-10 is coming soon; don't be caught off guard!

Thank You!

Questions? Comments?

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dickon.chan@cms.hhs.gov	415-744-3662
lolita.jacobe@cms.hhs.gov	415-744-3531

Does CMS Have Your Current Information?

- **Information for the VM and Physician Feedback reports comes from the Provider Enrollment, Chain and Ownership System (PECOS)**
  - **Your medical specialty**
  - **The state in which you practice**
  - **The location of your practice**
  - **Group practice affiliations**
  - **How to contact you**

- **Please update your information at: https://pecos.cms.hhs.gov**

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Where to Call for Assistance

- **QualityNet Help Desk:** 866-288-8912 (TTY 877-715-6222) , 7:00 a.m.–7:00 p.m. CST M-F or **qnetsupport@sdps.org**
  - Portal password issues
  - PQRS/eRx feedback report availability and access
  - IACS registration questions
  - IACS login issues
  - Program and measure-specific questions

(You will be asked to provide basic information such as name, practice, address, phone, and e-mail)

- **Provider Contact Center:**
  - Questions on status of 2012 PQRS/eRx Incentive Program incentive payment (during distribution timeframe)
  - See *Contact Center Directory at:*

    http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html

- **EHR Incentive Program Information Center:** 888-734-6433 (TTY 888-734-6563)

Web Resources

CMS eHealth Webpage

http://www.cms.gov/ehealth/

- **PQRS Website**
  - **http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/**
- **eRx Incentive Program Website**
  - **http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/**
- **Medicare and Medicaid EHR Incentive Programs**
  - **http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/**
- **Value Based Modifier (VBM)**
  - **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html**
- **Frequently Asked Questions (FAQs)**
  - **https://questions.cms.gov/**

Eligibility

	PQRS		Value Modifier		eRx		EHR Incentive Program		
	Eligible for Incentive	Subject to Payment Adjustment	Included in Definition of "Group" (1)	Subject to VM (2)	Eligible for Incentive (1)	Subject to Payment Adjustment (2)	Eligible for Medicare Incentive(3)	Eligible for Medicaid Incentive (4,5)	Subject to Medicare Payment Adjustment (7,8)
Medicare Physicians									
Doctor of Medicine	X	X	X	X	X	X	X	X	X
Doctor of Osteopathy	X	X	X	X	X	X	X	X	X
Doctor of Podiatric Medicine	X	X	X	X	X	X	X		X
Doctor of Optometry	X	X	X	X	X		X		X
Doctor of Oral Surgery	X	X	X	X	X		X	X	X
Doctor of Dental Medicine	X	X	X	X	X		X	X	X
Doctor of Chiropractic	X	X	X	X	X		X		X
Practitioners									
Physician Assistant	X	X	X		X	X		X (6)	
Nurse Practitioner	X	X	X		X	X		X	
Clinical Nurse Specialist (9)	X	X	X		X				
Certified Registered Nurse Anesthetist (10)	X	X	X		X				
Certified Nurse Midwife	X	X	X		X			X	
Clinical Social Worker	X	X	X		X				
Clinical Psychologist	X	X	X		X				
Registered Dietician	X	X	X		X				
Nutrition Professional	X	X	X		X				
Audiologists	X	X	X		X				
Therapists									
Physical Therapist	X	X	X		X				
Occupational Therapist	X	X	X		X				
Qualified Speech-Language Therapist	X	X	X		X				

Reporting Quality Data at the Group Level

Groups with 10+ EPs may select one of the following PQRS GPRO quality reporting mechanisms and meet the criteria for the CY 2016 PQRS payment adjustment to avoid the 2.0% VM adjustment

PQRS Reporting Mechanism	Type of Measure
1. GPRO Web interface	Measures focus on preventive care and care for chronic diseases (aligns with the Shared Savings Program)
2. GPRO using CMS-qualified registries	Groups select the quality measures that they will report through a PQRS-qualified registry.
3. GPRO using EHR	Quality measures data extracted from a qualified EHR product for a subset of proposed 2014 Physician Quality Reporting System quality measures.

Reporting Quality Data at the Individual Level – 50% Threshold Option

If a group does not report quality measures as a group, CMS will calculate a group quality score if at least 50% of the eligible professionals within the group report measures individually.

- **At least 50% of EPs must successfully avoid the 2016 PQRS payment adjustment**
- **EPs may report on measures available to individual EPs via the following reporting mechanisms:**
  - **Claims**
  - **CMS Qualified Registries**
  - **EHR**
  - **Clinical Data Registries (new for CY 2014)**