



## **AAO-HNS SUMMARY OF CY 2014 FINAL MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)**

On November 27, 2013, the Centers for Medicare & Medicaid Services (CMS) posted the final rule for payments in the Medicare physician fee schedule (MPFS) for calendar year (CY) 2014. In addition to payment policy and payment rate updates, the MPFS addresses a number of quality initiatives. The Academy will submit comments to CMS on the final rule by the January 27, 2014 deadline.

### **Notable AAO-HNS Regulatory Successes for CY 2014 Rulemaking Include:**

- Inclusion of [4 new Adult Sinusitis Measures](#) for CY 2014 PQRS reporting.
- Repeal of the Proposal to Cap 211 procedures (13 of which were ENT) which are paid at higher rate in the physician office at the lesser of the hospital or ASC practice expense payment rate.
- Positive revisions and corrections to the direct practice expense inputs for CPT 31231 Nasal Endoscopy, Dx.
- An increase in work RVU to CPT 13152 Complex repair from 4.90 in CY 2013 to 5.34 in CY 2014.
- CMS approval and finalization of 8 CPT codes presented at the AMA RUC during the CY 2013 cycle.
- Increased values for all 6 of the new Rigid Esophagoscopy CPT codes created in CY 2013. Click on the following hyperlinks for a [full summary of the Academy 2013 RUC/CPT Efforts](#) and associated [RVU chart](#).
- A reduction to the percentage threshold for successful reporting in PQRS from the prior 80% of beneficiaries to 50% of beneficiaries.

## **PROPOSED PAYMENT POLICIES FOR CY 2014**

### **1) Medicare Sustainable Growth Rate (SGR) (p. 533):**

The Medicare law includes the standard statutory formula that will require (absent Congressional intervention) a 20.1% reduction to the CY 2014 conversion factor (CF) under the Medicare PFS. This would result in a CY 2014 CF of \$27.006, as compared to the CY 2013 CF of \$34.0230. CMS notes that the CY 2013 CF, adjusted for budget neutrality to account for policies adopted in the final rule, would be \$35.6446. As this summary was being prepared, Congress took action to delay the 20+ percent cut for CY 2014 and passed a 3 month fix which includes a .5% update for physicians in 2014. It is anticipated that Congress will continue discussions related to full SGR repeal in early 2014 and the Academy will closely track those efforts and relay information to members as it becomes available. For more information on Academy efforts regarding SGR repeal during 2013, visit:

<http://www.entnet.org/Practice/members/Advocacy.cfm>

### **2) Estimated Overall Impact on Total Allowed Charges for ENT Services (Table 93)**

The overall impact of the CY 2014 final rule across otolaryngology-head and neck surgery procedures is – 2 percent. **It is important to note that these estimates DO NOT INCLUDE anticipated changes resulting from the recently passed SGR 3 month patch. Notably, we expect modification to the conversion factor for 2014 due to the .5% update included in the 3 month patch. The Academy will provide members with further detail regarding any delays to claims processing, or guidance from CMS in this regard, as soon as it becomes available.**

### **Adjusting RVUs to Revise Practice Expense (PE) RVU Weights under Revised Medicare Economic Index (MEI) (p. 50)**

To fully understand the -2% impact to Otolaryngology for CY 2014, members should be aware of the changes CMS is making to PE RVUs as they relate to the Medicare Economic Index formula. Within the final rule, CMS is finalizing revisions to the MEI based on the recommendations of the MEI Technical Advisory Panel (TAP). The MEI is an index that measures the price change of the inputs used to furnish physician services. This measure was authorized by statute and is developed by the CMS Office of the Actuary. CMS believes that the MEI is the best measure available of the relative weights of the three components in payments under the PFS; work, PE and malpractice. Accordingly, CMS believes that to assure that the PFS payments reflect the resources in each of these components the RVUs used in developing rates should reflect the same weights in each component as the MEI. CMS states they will accomplish this by holding the work RVUs constant and adjusting the PE RVUs, the Malpractice RVUs and the CF to produce the appropriate balance in RVUs among components and payments. ***The overall result of this policy change is that practitioners who furnish services with a higher proportion of PE RVUs (such as ENTs) will be most directly affected and should expect to see reductions across the board to PE RVUs for their services. This is reflected in the impact table below.***

(A) Specialty	(B) Allowed Charges (mil)	Impact of RVU Changes		(E) Impact of Adjusting the RVUs to Match the Revised MEI Weights	(F) Combined Impact
		(C) Impact of Work and MP RVU Changes	(D) Impact of PE RVU Changes		
<b>30-OTOLARNGOLOGY</b>	<b>\$1,133</b>	<b>0%</b>	<b>-1%</b>	<b>-1%</b>	<b>-2%</b>
43-AUDIOLOGIST	\$57	0%	1%	-1%	0%
52-ORAL /MAXILLOFACIAL SURGERY	\$45	0%	1%	-2%	-1%
34-PLASTIC SURGERY	\$372	0%	0%	0%	0%
07-DERMATOLOGY	\$3,123	-1%	1%	-2%	-2%
13-GENERAL SURGERY	\$2,254	0%	0%	0%	0%

### 3) Practice Expense (PE) (p. 26)

#### **Reduction to Office PE RVUs that Exceed OPPS/ASC Facility Payment Rates (p. 68):**

Within the proposed rule, CMS proposed a major change to the methodology for setting practice expense RVUs for services under the PFS. **They proposed to limit the office PE RVUs for individual codes so that the total office MPFS payment amount would not exceed the total combined amount Medicare pays for the same code in the facility (hospital or ASC) setting.** Specifically, they proposed to use Medicare hospital outpatient prospective payment system (OPPS) and Ambulatory Surgical Center (ASC) payment amounts to “cap” the practice expense (PE) relative value units (RVUs) for certain physicians’ services furnished in the physician office setting. CMS rationalized this policy based on their concern that the current basis for estimating the resource costs (i.e. utilizing invoices or quotes submitted via the RUC process) involved in furnishing a PFS service is significantly encumbered by their inability to obtain accurate information regarding supply and equipment prices, as well as procedure time assumptions. They felt this proposal would lessen the negative impact of those difficulties on both the appropriate relativity of PFS services, and overall Medicare spending. As members recall, this policy would have significantly impacted 13 Otolaryngology services by reducing their payment 6-60% for CY 2014, if finalized.

*Happily, thanks to extensive advocacy efforts by the Academy, Congress, AMA, industry partners, and other specialty societies, CMS has chosen to **retract** this policy proposal within the 2014 final rule. Specifically, CMS stated that they greatly appreciated all of the comments received on this proposal and given the thoughtful and detailed technical comments they received; they **are not finalizing** the proposed policy. They will consider more fully all comments received, including those suggesting technical improvements to the proposed methodology. After further consideration of the comments, they expect to develop a revised proposal for using OPSS and ASC rates in developing PE RVUs which they will propose through future notice and comment rulemaking. They further clarify that they do not believe that the standard process for evaluating potentially misvalued codes, including the use of the AMA RUC, is an effective means of addressing these codes, as they do not believe that the direct practice expense information they use to value these codes is accurate, or reflects typical resource costs. In fact, they believe the current review process for direct PE inputs only accommodates incomplete, small sample, and potentially biased or inaccurate resource input costs that may distort the resources used to develop non-facility (office) PE RVUs used in calculating PFS payment rates for individual services, and therefore, **CMS plans to revisit this issue in future rulemaking.***

#### **CMS Finalizes 90% Equipment Use Rate for Imaging Services in CY 2014 (p. 42, Table 3)**

CMS currently uses an equipment utilization rate assumption (which is part of the overall calculation used to derive practice expense RVUs for services) of 50 percent for most equipment, with the exception of expensive diagnostic imaging equipment. For CY 2013, expensive diagnostic imaging equipment, which is equipment priced at over \$1 million (for example, computed tomography (CT) and magnetic resonance imaging (MRI) scanners), CMS used an equipment utilization rate assumption of 75 percent. Under the Social Security Act (SSA), as modified by the American Taxpayers Relief Act (ATRA), the equipment use rate for determining PE RVUs for expensive diagnostic imaging equipment was raised to a 90 percent assumption for CY 2014. Based on this, CMS is finalizing the 90 percent utilization rate assumption

in CY 2014 to all of the services to which the 75 percent equipment utilization rate assumption applied in CY 2013. ***This means all services impacted by this policy will see a reduction in practice expense RVUs for CY 2014.*** A table of impacted services, ***including common head and neck imaging services,*** can be found [here](#).

**4) Potentially Misvalued Services Under the Fee Schedule (p. 102)**

In recent years CMS and the AMA Relative Update Committee (RUC) have taken increasingly significant steps to address potentially misvalued codes. Most recently, the categories examined included potentially misvalued services in seven categories including those with the fastest growth, families that have experienced substantial changes in practice expenses, new technology, codes frequently billed together, those with low RVUs billed multiple times for a single treatment, and those that have not been RUC reviewed.

In CY 2013, CMS finalized their proposal from 2012 to allow public nomination of potentially misvalued codes which should be considered for review. Within the 2014 rulemaking cycle, no codes were nominated by the public as potentially misvalued / requiring review. CMS is also exploring new ways to broaden the process of identifying potentially misvalued codes, and for the CY 2014 they proposed, and ***are now finalizing,*** a new process whereby they will solicit feedback from Medicare Contractor Medical Directors (CMDs) in developing a list of potentially misvalued codes. ***The Academy commented on this proposed policy in our August comments on the proposed CY 2014 rule. CMS responded to several of our concerns, including our request that CMDs submit a rationale for placing a code on the potentially misvalued list, and noted that CMDs will simply assist CMS in identifying potentially misvalued codes and CMS will then evaluate their suggestions and post them in the proposed rules for public comment. This will allow affected specialties to comment as to whether or not the codes should be evaluated as potentially misvalued. Of note, no codes identified by the CMDs for CY 2014 review impact our specialty.***

**5) Improving Valuation of the Global Surgical Package (p. 110)**

In the CY 2013 proposed rule, CMS sought comments on methods of obtaining accurate and current data on E/M services furnished as part of a global surgical package. Commenters provided a variety of suggestions including comments from the AMA RUC noting that the hospital and discharge day management services included in the global period for many surgical procedures may have been inadvertently removed from the time file in 2007. CMS said in the CY 2013 final rule with comment period that they would review this file and, if appropriate, propose modifications to the physician time file in the CY 2014 PFS proposed rule. After extensive review, ***CMS agrees that the data were deleted from the time file due to an inadvertent error, as noted by the AMA RUC. Thus, they are replacing the missing post-operative hospital E/M visit information and time for the 117 codes that were identified by the AMA RUC. Nine of the 117 CPT codes noted by the AMA RUC are provided by Otolaryngology, and will be adjusted for CY 2014 accordingly, including:***

**TABLE 13: Physician Time Changes for CY 2014 Potentially Misvalued Codes**

<u>CPT Code</u>	<u>Descriptor</u>	<u>AMA RUC-Recommended Visits</u>				<u>CY 2013 MD Time</u>	<u>CY 2014 Physician Time</u>
		<u>99231</u>	<u>99232</u>	<u>99238</u>	<u>99291</u>		
<b>20100</b>	Explore wound neck	2		1		218	266
<b>21139</b>	Reduction of forehead	1		1		400	466
<b>21151</b>	Reconstruct midface lefort	2		1	1	567	686
<b>21154</b>	Reconstruct midface lefort	2.5		1	1.5	664	853
<b>21155</b>	Reconstruct midface lefort	2		1	2	754	939
<b>21175</b>	Reconstruct orbit/forehead		1	1	2	549	767
<b>21182</b>	Reconstruct cranial bone		1	1	2	619	856
<b>21188</b>	Reconstruction of midface	1		1		512	572
<b>31582</b>	Revision of larynx	8	1			489	654

**6) Validating RVUs of Services (p. 101)**

Under the ACA, the Secretary is directed to validate a sampling of RVUs for services identified by the seven categories (listed in section 4 above). ***In the CY 2013 proposed rule, CMS informed the public of their intent to, “enter into a contract to assist them in validating RVUs of potentially misvalued codes that will explore a model for the validation of physician work under the PFS, both for new and existing services.”*** Both contracts will extend over a 2 year period. Specifically, the RAND Corporation will use available data to build a validation model to predict work RVUs and the individual components of work RVUs, time, and intensity. Urban Institute will focus on the central role of time in establishing work RVUs and the concerns that have been raised about the current time values. A key focus of the project

is collecting data from several practices for services selected by the contractor. The data will be used to develop time estimates. The project team will include groups of physicians from a range of specialties to review the new time data and their potential implications for work and the ratio of work to time. This may impact the role of the AMA RUC in the future and is being closely monitored by the Academy. **CMS did not release any new information in the CY 2014 Final MPFS in this regard, but noted that additional information is available on the CMS website regarding the contractors' projects.**

#### **7) Multiple Procedure Payment Reduction Policy (MPPR) (p. 115)**

Within the final rule for CY 2014, CMS notes that they are not adopting any new MPPR policies for CY 2014, however, they will continue to look at expanding the MPPR based on efficiencies when multiple procedures are furnished together. *They do clarify however, that within Addendum H, which lists therapy services subject to the MPPR that the four new Speech evaluation CPT codes (92521-92524) will be added and the MPPR policies will apply to these services for CY 2014. They also note that these new codes are “always therapy” services that are only paid by Medicare when furnished under a therapy plan of care.*

#### **8) Requirements for Billing “Incident To” Services (p. 574)**

The Social Security Act (SSA) establishes the Medicare benefit category for services and supplies furnished as “incident to” the professional services of a physician and specifies that “incident to” services and supplies are “of kinds which are commonly furnished in physicians’ offices and are commonly either rendered without charge or included in physicians’ bills.” In addition, there are regulations specific to each type of practitioner (clinical psychologists, PAs, NPs, clinical nurse specialists, and certified nurse-midwives) allowed to bill for “incident to” services. *Within the final rule, CMS finalized their proposal to require individuals performing “incident to” services meet any applicable requirements to provide the services, including licensure, imposed by the state in which the services are being furnished. In our comments on the proposed rule, the Academy supported this proposal as we felt it would only increase the quality of care and safety for Medicare beneficiaries. CMS finalized this proposal for CY 2014 and the new regulatory requirements will take effect January 27, 2014.*

#### **9) Liability for Overpayments to Individuals; Including Payments to Providers or Other Persons (p. 698)**

Within the 2014 final rule, CMS finalized their proposal to modify the language of the Social Security Act (SSA) ((based on statutory directive from the American Taxpayers Relief Act (ATRA)) such that Medicare is able to recoup overpayments identified up to 5 years after the service is inappropriately reimbursed. This is an extension of the timeframe from the previous 3 year period under the original SSA language. Under the statute, CMS may waive the recovery of an overpayment to a provider of services when they are “without fault” in incurring the overpayment. This means the provider is not responsible for causing the overpayment. Providers can also be exempt after the 5 year period; if it is deemed that recoupment of the overpayment would be “against equity and good conscience.” Per the statute, it would be against equity and good conscience to recoup the overpayment after 5 years if the provider is deemed to be “without fault.” *The key thrust of this policy change is that providers are now subject to a longer period of time within which CMS can audit and recoup funds for overpayments deemed “not medically necessary”.*

### **QUALITY INITIATIVE CHANGES**

#### **10) Physician Compare Website (p. 702)**

Under the Accountable Care Act (ACA), CMS is required to develop a Physician Compare website with information on physicians enrolled in the Medicare program, as well as information on other eligible professionals (EPs) who participate in PQRS. CMS is also required to implement a plan for making publicly available through the website, information on physician performance that provides comparable information on quality and patient experience measures. By January 1, 2015, CMS must send a report to Congress on Physician Compare development, including information on efforts and plans to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice.

In 2013, CMS released a redesigned Physician Compare website, which can be found at: [www.medicare.gov/physiciancompare](http://www.medicare.gov/physiciancompare). The primary source of administrative information on Physician Compare is from the Provider Enrollment, Chain, and Ownership System (PECOS), with the use of Medicare claims information to verify the information in PECOS. Providers must ensure information is up-to-date and accurate in the national PECOS database. To update information not found in PECOS, such as hospital affiliation and foreign language, providers should contact the Physician Compare team directly at [physiciancompare@westat.com](mailto:physiciancompare@westat.com).

**Information that is currently reflected on the site includes:** address, education, American Board of Medical Specialties (ABMS) board certification information, primary and secondary specialties, group affiliations, hospital affiliations that link to the hospital’s profile on Hospital Compare as available, Medicare Assignment status, and Provider language skills.

Within the final rule, **CMS finalized the following proposals:**

- **For CY 2014, CMS has finalized its proposal to expand the quality measures posted on Physician Compare by publicly reporting in CY 2015 performance on all measures collected through the GPRO web interface for groups of all sizes participating in PQRS reporting for CY 2014. Accountable Care Organizations (ACOs) participating in the MSSP will also have their performance on the ACO GPRO measures reported in the same manner.**
- **No earlier than 2015, CMS plans to post group performance on the GPRO registry and EHR measures identified that can be reported via the GPRO web interface in 2014.**
- **CMS also plans to publicly report CG-CAHPS measures for groups of 100 or more EPs reporting via GPRO as well as for ACOs in the MSSP program, and noted that they are working to ensure that a greater set of measures are available for public reporting to help more group practices find measures that are relevant to them and to ease the burden of reporting.**
- **CMS will publicly report performance on patient experience measures for 2014 both for group practices and ACOs and for group practices of 25 or more professionals who choose to voluntarily report Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) data as part of their participation in the PQRS GPRO.**
- **CMS will report performance on 20 measures listed in the proposed rule that are reported by individual eligible professionals reporting through an EHR, registry, or claims during 2014 under the PQRS.**

**11) Value Based Payment Modifier (VBM) (p. 1157)**

The VBM assesses both quality of care furnished and the cost of care under the MPFS. CMS has begun with a phase-in of the VBM in 2015, which **will apply to all physicians by January 1, 2017.** Implementation of the VBM is based on participation in Physician Quality Reporting System (PQRS). For CY 2013, the VBPM applies to groups of physicians with 100 or more EPs. *In 2014, CMS is expanding this to groups with 10+ EPs.* Specifics on 2014 VBM requirements are outlined below and additional information is available on the Academy website at: <http://bit.ly/entVBPM>.

Value Modifier Components	2015 Finalized Policies	2016 Finalized Policies (take effect in 2014)
Performance Year	<b>2013</b>	<b>2014</b>
Group Size	100+	<b>10+</b>
Available Quality Reporting Mechanisms	GPRO-Web Interface, CMS Qualified Registries, Administrative Claims	GPRO-Web Interface, CMS Qualified Registries, <b>EHRs, OR 50% of EPs reporting individually</b>  <i>**note: CMS expects to raise this % threshold in future years**</i>
Quality / Outcome Measures	<ul style="list-style-type: none"> <li>• Measures reported through the GPRO PQRS reporting mechanism selected by the group <b>OR</b> individual measures reported by at least 70% of the EPs within the group</li> <li>• All Cause Readmission</li> <li>• Composite of Acute Prevention Quality Indicators: (bacterial pneumonia, urinary tract infection, dehydration)</li> <li>• Composite of Chronic Prevention Quality Indicators: (chronic obstructive pulmonary disease (COPD), heart failure, diabetes)</li> </ul>	<p>These requirements are the same for CY 2014 reporting, however, CMS also:</p> <ul style="list-style-type: none"> <li>• finalized that groups of physicians with 25 or more eligible professionals will be able to elect to have the patient experience of care measures collected through the PQRS CAHPS for CY 2014 included in their payment modifier for CY 2016.</li> <li>• If all the EPs in the group satisfactorily participate in a PQRS qualified clinical data registry in CY 2014 and CMS cannot receive quality performance data from such registry, CMS will classify the group’s quality composite score as “average” because they would not have data to reliably indicate whether the group should be classified as high or low quality.</li> </ul>
Patient Experience of Care Measures	N/A	<b>PQRS CAHPS: Option for groups of 25+ EPs</b>

<b>Cost Measures</b>	1) Total per capita costs measure (annual payment standardized and risk-adjusted Part A and Part B costs)  2) Total per capita costs for beneficiaries with four chronic conditions: COPD, Heart Failure, Coronary Artery Disease, Diabetes	Same as 2015 and <b>Medicare Spending Per Beneficiary measure</b> (includes Part A and B costs during the 3 days before and 30 days after an inpatient hospitalization)
<b>Benchmarks</b>	Group Comparison	<b>Specialty Adjusted Group Cost</b>  CMS also finalizes a specialty adjustment that allows for peer group comparisons related to the new cost measure for CY 2015.
<b>Quality Tiering</b>	Optional	<b>Mandatory</b> Groups of 10-99 EPs receive only the upward or neutral adjustment, no downward adjustment. Groups of 100+ are subject to an upward, neutral or downward adjustment.  **CMS notes that groups of 100+ that furnish high quality care at high cost, for CY 2014 reporting, will not be subject to a payment penalty**
<b>Payment at Risk</b>	-1.0%	<b>-2.0% if you don't participate in PQRS</b>  <b>-2% if you're 100+ and provide low quality/high cost care</b>  <b>-1% if you're 100+ and provide either low quality/average cost or average quality/high cost care.</b>
<b>Physician Feedback Reports (QRURs)</b>	Reports sent to 24,000 providers in Iowa, Kansas, Missouri and Nebraska.	<b>On September 16, 2013 groups with 25+ EPs received Quality Resource Use Reports (QRURs) which reflect their performance on quality and cost reporting measures based on their 2012 PQRS reporting. All physicians can expect QRURs in late summer of 2014.</b>

## 12) Physician Quality Reporting System (PQRS) (p. 1251)

### PQRS Incentives and Penalties in 2014 and Beyond

CMS proposes aligning the criteria for earning an incentive payment and being penalized based on 2014 reporting. For 2014, CMS sets the incentive payment for satisfactory participation in PQRS at .05% of all Medicare Part B charges. *For 2014 and beyond, CMS has set the penalty for unsatisfactory participation in PQRS at -2% of all Medicare Part B charges. Incentives are awarded in the performance year and penalties are applied to the reporting year, which is 2 years after the reporting year (e.g. 2014 reporting penalties would be applied to 2016 payments).*

### PQRS Changes in 2014

#### CMS Changes to Measures and Measure Groups for CY 2014 Reporting

- **CMS FINALIZED 285 individual measures for inclusion in the 2014 PQRS program, including 4 of the Academy's Sinusitis Measures for inclusion in 2014 and beyond.**
  - CMS responded to our inquiry as to why this was only approved for reporting via registry and stated that for all new measures they are approved for registry only initially, however, they will continue to work toward complete alignment and if possible will include this measure for EHR-Based reporting in the future.
- **CMS did not finalize the proposed increase in the minimum number of measures in a measures group from 4 to 6 for CY 2014.** They do state, however, that they plan to increase this minimum number in the future. As a result, CMS also does not finalize the proposed addition of measures to measures groups with less than 6 measures. CMS adds that it will work with the measure developers and owners of these measures groups to appropriately add measures to measures groups that only contain four measures.
- **CMS finalized the General Surgery measures group for 2014** (but removed PQRS measure #130: Documentation of Current Medications in the Medical Record and PQRS measure #226: Preventive Care, and without the proposed Iatrogenic Injury to Adjacent Organ/Structure measure from the finalized measure group), and combines the proposed

Gastrointestinal Surgery measures group with the General Surgery measures group to decrease reporting burden on EPs.

- **CMS is deleting 10 measures** that were previously reportable by ENTs or their practices, including: Referral for otologic evaluation for patients with congenital or traumatic deformity of the ear (deleted due to low utilization); eight Functional Communication Measures previously stewarded by ASHA (deleted due to loss of measure owner support); and Smoking and Tobacco use cessation, medical assistance (deleted due to EHR MU Stage 2 alignment).

#### **CMS Changes to Reporting Methods for CY 2014**

- CMS eliminated the option to report measure groups via claims for individual EPs in CY 2014. Individuals may now ONLY reporting measure groups via registry.
- CMS reduced the percentage of patients EPs must report on using Registry reporting from the previous 80% to 50% for CY 2014 reporting. This is now consistent with the patient threshold requirements for reporting via claims.

#### **Changes to Individual Reporting in CY 2014**

- **Reporting via Claims** – CMS has increased the number of measures Individual EPs must report on from the prior 3 to 9 measures (across 3 quality domains, for 50% of beneficiaries) for CY 2014 reporting. EPs who report on fewer than 9 measures will be subject to the [Measure Applicability Validation \(MAV\) process](#). CMS also has a [flow process chart](#) which outlines how the MAV analysis works under the PQRS program.
- **Reporting via Registry** – CMS has increased the number of measures Individual EPs must report on from the prior 3 to 9 measures (across 3 quality domains, for 50% of beneficiaries) for CY 2014 reporting. EPs who report on fewer than 9 measures will be subject to the MAV process.
- **Reporting via Qualified Clinical Data Registry (QCDR)- NEW** – CMS finalized the new QCDR reporting option for individual reporting in CY 2014.
- **CMS finalized exceptions for individuals reporting via Claims and Registries for CY 2014 to avoid 2016 payment penalty.** These EPs will not be eligible for the 2014 bonus payment, however. *See detail below.*

#### **Changes to Group Reporting in CY 2014**

- CMS revised the deadline by which Group Practices choosing to report for PQRS via the Group Practice Reporting Option (GPRO) must self-nominate from the previous October 15<sup>th</sup> of the reporting year, to a new deadline of September 30<sup>th</sup> of the reporting year.
- CMS finalized a new group reporting option for groups of 25-99 EPs to report, via a CMS-certified survey vendor, on the CG-CAHPS survey measures. Groups selecting this reporting option will need to report using additional reporting methods in order to report on additional measures to meet the criteria for satisfactory reporting for CY 2014.
- CMS added the requirement for CY 2014 that groups of 25+ who wish to report the CG-CAHPS patient satisfaction survey measures must indicate their intent to do so when they register for the PQRS program. CMS also finalized a change to utilize a single website for Groups to self-nominate to use the GPRO reporting option as well as indicate they would like to report on CG-CAHPS measures for CY 2014.
- CMS added the requirement that groups of 100+ must report on all CG-CAHPS measures as well as the GPRO measures in the web interface.

#### **13) Electronic Health Record Incentive Program (EHR) (p. 1124)**

CMS finalized its proposal that EPs may use a qualified clinical data registry to report clinical quality measures (CQMs) that meet both EHR Meaningful Use and PQRS quality reporting specifications. EPs would report 9 CQMs in the Stage 2 EHR final rule covering at least 3 domains, or if an EP does not have data for at least 9 CQMs covering at least 3 domains, the EP reports CQMs for which there is data and reports the remaining CQMs as “zero denominators”.

EPs who seek to report CQMs electronically under the Medicare EHR Incentive Program must use the most recent version of the electronic specifications for the CQMs (June 2013 version) and have certified electronic health record technology (CEHRT) that is tested and certified to the most recent version of the electronic specifications for the CQMs. EPs that do not wish to report CQMs electronically using the most recent version of the electronic specifications (for example, if their CEHRT has not been certified for that particular version) will be allowed to report CQM data to CMS by attestation for the Medicare EHR Incentive Program. EPs must ensure that their CEHRT has been tested and certified to the June 2013 version of the CQMs for the purpose of achieving the CQM component of meaningful use in 2014. For attestation, CMS is not requiring that products reporting on older versions of the electronic specifications for the CQMs have CEHRT that is tested and certified to the most recent version, but rather, if attesting to older versions it is sufficient that the product is CEHRT certified to the 2014 Edition certification criteria.

*Of note, the qualified clinical data registry reporting option is only for EPs who are beyond their first year of demonstrating meaningful use. EPs who are first time meaningful EHR users must report CQMs via attestation as established in the EHR Incentive Program Stage 2 final rule.* Further, although CMS did not propose to change the established reporting periods, CMS has stated they will accept reporting periods of different CQMs and for meaningful use functional measures, as long as the quarters are within CY 2014.

#### **14) Updating Existing Standards for E-Prescribing under Medicare Part D (p. 1235)**

Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS is charged with the adoption of Part D e-prescribing standards. Prescription Drug Plan (PDP) sponsors and Medicare Advantage (MA) organizations offering Medicare Advantage Prescription Drug Plans are required to establish electronic prescription drug programs that comply with the e-prescribing standards. Prescribers and dispensers who electronically transmit prescriptions for covered drugs prescribed for Medicare D eligible beneficiaries, are also required to comply with any applicable standards that are in effect. CMS has utilized several rounds of rulemaking to adopt standards for e-prescribing.

CMS' final rule differs from their proposals in the 2014 proposed rule, specifically, CMS agreed that the original timeline may have been aggressive, and therefore, **CMS has decided to move the effective date to early 2015.** Version 1.0 will retire on February 28, 2015 and Version 3.0 will be adopted as the official Part D e-prescribing standard effective March 1, 2015. **Retirement of Version 1.0 will be effective February 28, 2015, and the adoption of Version 3.0 as the official Part D e-prescribing standard, will be effective March 1, 2015.**

#### **15) Medicare Shared Savings Program (p. 1137)**

Under the Shared Savings Program, ACOs are currently required to report on 33 quality performance measures. For ACOs beginning their agreement period in April or July 2012, there are two reporting periods in the first performance year, corresponding to CY 2012 and 2013. For ACOs beginning their agreement periods in 2013 or later, both the performance year and the reporting period will correspond to the CY.

*Beginning in 2015, a PQRS payment adjustment will apply to EPs who are not satisfactory reporters. The penalty in CY 2015 will be -1.5%, increasing to -2% for CY 2016 and subsequent years.* For the 2014 reporting period (2016 PQRS payment adjustment) and subsequent years, *CMS finalized their proposal to align the ACO reporting requirements with the traditional PQRS GPRO requirements and require that ACOs satisfactorily report the 22 ACO GPRO measures during the 2014 and subsequent reporting periods to avoid the downward payment adjustments.* CMS also finalized that ACO providers/suppliers who are EPs may only participate under their ACO participant TIN for purposes of the payment adjustment in 2016 and subsequent years. ACO providers/suppliers who are EPs that bill under a non-ACO participant TIN during the year need to participate under the traditional PQRS as either an individual or group practice for purposes of avoiding the PQRS payment adjustment for the claims billed under the non-ACO participant TIN.

In the final rule, CMS indicated they would not compare an ACO's quality performance to the performance of other ACOs for determining an ACO's overall quality score but did acknowledge that they would work to incorporate actual ACO performance on quality measures into the quality benchmarks. For the 2014 reporting period, CMS plans to:

- Use all available fee for service quality data, including data submitted by MSSP and Pioneer ACOs, to set the performance benchmarks for 2014 and subsequent reporting periods;
- Use all available fee-for-service quality data to calculate benchmarks, including ACO data, except where performance at the 60th percentile is equal to or greater than 80 percent for individual measures, regardless of whether or not the measure is clustered. CMS chose 80 percent because this level of attainment indicates a high level of performance and they believe ACOs achieving an 80 percent performance rate should not be penalized as low performers.

#### **Additional Information**

The CY 2014 Final MPFS rule with comment period on interim policies is published at:

[http://www.ofr.gov/OFRUpload/OFRData/2013-28696\\_PL.pdf](http://www.ofr.gov/OFRUpload/OFRData/2013-28696_PL.pdf). CMS will respond to comments in the CY 2014 MPFS final rule. The electronic submissions of comment can be made at URL: [www.Regulations.gov](http://www.Regulations.gov) search for CMS and final rules.