Summary of 2015 Physician Value-based Payment Modifier Policies

- **What is the Value Modifier?**
  The Value Modifier provides for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule based upon the quality of care furnished compared to cost during a performance period.

- **When will Medicare apply the Value Modifier?**
  Beginning in calendar year (CY) 2015, Medicare will apply the Value Modifier to physician payments under the Medicare Physician Fee schedule for physicians in groups of 100 or more eligible professionals.

- **What is the performance period for the Value Modifier?**
  CY 2013 is the performance period for the Value Modifier that will be applied to payments in CY 2015.

- **Does the Value Modifier apply to payments for physicians who do not participate in the Medicare program (non-participating physicians)?**
  Yes. In CY 2015, Medicare will apply the Value Modifier to physician payments under the Medicare Physician Fee Schedule for participating **and** non-participating physicians in groups of 100 or more eligible professionals.

- **How is a "group of physicians" defined for the Value Modifier?**
  Group of physicians is defined as a single Taxpayer Identification Number (TIN) with 2 or more individual eligible professionals, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN.

- **How does Medicare determine whether a group of physicians has 100 or more eligible professionals?**
  We use a two-step process:

1. We query Medicare's Provider Enrollment, Chain, and Ownership System (PECOS) to identify groups of physicians with 100 or more eligible professionals as of October 15, 2013. This inquiry generates a list of potential groups that could be subject to the Value Modifier for CY 2015.

2. To ensure that the group actually had 100 or more eligible professionals during 2013, we analyze claims for services furnished during the CY 2013 performance year through at least February 28, 2014. We remove a group from the October 15 PECOS list that did not have 100 or more eligible professionals that billed under the group's TIN during 2013. We will NOT add groups to the October 15 PECOS list.

- **How will Medicare determine the Value Modifier in CY 2015?**
  We categorize groups of physicians with 100 or more eligible professionals into two categories:

Category 1: Value Modifier = 0.0% OR Group Elects Quality-Tiering. The first category includes those groups of physicians that:
(a) have self-nominated/registered for the Physician Quality Reporting System (PQRS) as a group and reported at least one measure, or
(b) have elected the PQRS Administrative Claims option as a group.

Quality-Tiering Election: Groups within Category 1 can elect to have their Value Modifier calculated using the quality-tiering methodology. For groups that make this election, we will use the performance rates on the quality measures reported through the PQRS reporting mechanisms (e.g., Group practice reporting option (GPRO) web-interface, CMS-qualified registry, or PQRS Administrative Claims option) and the three outcome measures to calculate their Value Modifier. **Calculation of the Value Modifier under the quality-tiering election will result in an upward, downward, or no payment adjustment based on performance.** If a group that elects quality-tiering self-nominates/registers for the GPRO web-interface or CMS-qualified registry and does not meet the satisfactory reporting criteria for the PQRS incentive payment, we will use the group's performance on the Administrative Claims option to calculate the Value Modifier.

Category 2: Value Modifier = -1.0%. The second category includes groups that do not fall within either of the two subcategories (a) or (b) of Category 1.

- **What is the deadline to select the CY 2013 PQRS reporting mechanism and to elect quality-tiering?**
  Groups of physicians must self-nominate/register as a group and select their PY 2013 PQRS reporting mechanism and, if they choose to do so, elect the quality-tiering methodology to calculate the Value Modifier by October 15, 2013.

- **What is the relationship between the PQRS and the Value Modifier?**
  Our overall approach to implementing the Value Modifier is based on participation in the PQRS. Groups of physicians with 100 or more eligible professionals must participate in the PQRS by self-nominating/registering for the PQRS as a group and reporting at least one measure, or electing PQRS Administrative Claims option in order to avoid the -1.0% downward Value Modifier payment adjustment. If the group elects quality-tiering, then calculation of the Value Modifier could result in an upward, downward, or no payment adjustment based on performance.

  Groups whose physicians participate as individuals under the PQRS must register as a group and elect the Administrative Claims reporting mechanism by October 15, 2013 in order to avoid the -1.0% downward Value Modifier payment adjustment.

Detailed Information on the 2015 Physician Value-based Payment Modifier Policies

I. Overview

Section 1848(p) of the Social Security Act (Act) requires that Medicare establish a value-based payment modifier (Value Modifier) that provides for differential payment under the Medicare Physician Fee Schedule (PFS) based upon the quality of care furnished compared to cost during a performance period. Section 1848(p) requires that the Value Modifier be applied 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. The statute requires the Value Modifier to be budget neutral. Budget-neutrality means that, in aggregate, the increased payments to high performing physicians and groups of physicians equal the reduced payments to low performing physicians and groups of physicians.

Beginning in calendar year (CY) 2015, we will apply the Value Modifier to all groups of physicians with 100 or more eligible professionals. We anticipate making proposals in future rulemaking on how to apply the Value Modifier to groups with fewer than 100 eligible professionals and to solo practitioners.

Our overall approach to implementing the Value Modifier is based on participation in the Physician Quality Reporting System (PQRS). Therefore, we urge solo practitioners and physicians in smaller groups to participate in the PQRS now, because when we propose in future rulemaking to apply the Value Modifier to smaller groups and solo practitioners, we anticipate basing the quality composite on PQRS quality data reported by such physicians.

We also anticipate that we would propose to increase the amount of payment at risk for the Value Modifier as we gain additional experience with the methodologies used to assess the quality of care, and the cost of care, furnished by physicians and groups of physicians.

The Value Modifier applies only to physician payments under the Medicare PFS. The Value Modifier does not apply to payments that are NOT made under the Medicare PFS, including those for physicians providing services in Rural Health Clinics, Federally Qualified Health Centers, and Critical Access Hospitals (CAHs) (for CAHs electing method II billing).

Additionally, for 2015 and 2016, the Value Modifier does not apply to groups of physicians in which any of the group's physicians participate in the Medicare Shared Savings Program Accountable Care Organizations (ACOs), the testing of the Pioneer ACO model, or the Comprehensive Primary Care Initiative.

II. Recommended Actions for Groups of Physicians with 100 or More Eligible Professionals

1. Participate in the PQRS in 2013:

    - Self-nominate/register during one of two time periods - either during the first period from December 1, 2012 to January 31, 2013 or during a second period from July 15 – October 15, 2013.
    - Select a PQRS GPRO reporting mechanism (web interface, CMS-qualified registry, or Administrative Claims option). A group that self-nominated during the first period will be able to change its PQRS reporting mechanism during the second period.

      NOTE: Groups with 100 or more eligible professionals whose physicians participate as individuals under the PQRS must register as a group and elect the Administrative Claims reporting mechanism by October 15, 2013.

2. Decide whether to elect the quality-tiering approach to calculate the group's 2015 Value Modifier and, if the group chooses to do so, make an election by October 15, 2013.

3. Report at least one measure if the group selected the web interface or CMS-qualified registry mechanism.

Groups of physicians with 100 or more eligible professionals must take these actions in order to avoid falling under Category 2, and consequently, being subject to the -1.0% downward Value Modifier payment adjustment in CY 2015.

III. Application of the Value Modifier

(1) Definition of a Group, Group Size, and Application of the Value Modifier to the Paid Amount

- For purposes of establishing group size, we use the definition of an **eligible professional** as specified in section 1848(k)(3)(B) of the Act. Eligible professionals consist of:
    - Physicians
        - Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Dental Surgery, Doctor of Dental Medicine, Doctor of Chiropractic
    - Practitioners
        - Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist, Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, Audiologists
    - Therapists
        - Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist

We define a **group of physicians** as a single Taxpayer Identification Number (TIN) with 2 or more individual eligible professionals, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN.

- We identify whether a group has 100 or more eligible professionals using a two-step process:

    - We query Medicare's Provider Enrollment, Chain, and Ownership System (PECOS) to identify groups of physicians with 100 or more eligible professionals as of October 15, 2013. This query will produce a list of potential groups that could be subject to the Value Modifier.
    - To ensure that the group actually had 100 or more eligible professionals during 2013, we will analyze the group's (TIN's) claims submitted for services furnished during 2013, including at least a 60-day claims run out (that is, we will analyze claims submitted through at least February 28, 2014 for services furnished during the CY 2013 performance year). We will remove a group of physicians from this list if the group does not have at least 100 eligible professionals that billed under the group's TIN during 2013. We note that we will not add groups to the October 15 PECOS list based on this claims analysis, rather we will only remove groups that, based on claims, do not have 100 or more eligible professionals.

We will apply the Value Modifier for CY 2015 to the Medicare **paid** amounts for the items and services billed under the PFS at the TIN level so that beneficiary cost-sharing is not affected. We will apply it to the items and services billed by physicians under the TIN, not to other eligible professionals that also may bill under the TIN. Application of the Value Modifier at the TIN level means that if a physician changes groups from TIN A in the performance period (CY 2013) to TIN B in the payment adjustment period (CY

2015), we would apply TIN B's Value Modifier to the physician's payments for items and services billed under TIN B during 2015.

(2) Approach to Setting the Value Modifier Adjustment Based on PQRS Participation and the Quality-Tiering Option

We finalized a two-category approach to phase in the Value Modifier in 2015 to groups of physicians with 100 or more eligible professionals (see Figure 1). Groups in Category 1 may elect the quality-tiering methodology to calculate the Value Modifier to be applied to their PFS payments in CY 2015. Specifically, we categorize groups of physicians eligible for the Value Modifier into two categories:

(1) Category 1 includes groups of physicians that:
(a) have self-nominated/registered for the PQRS as a group and reported at least one measure, or
(b) have elected the PQRS Administrative Claims option as a group.

Note: Groups in Category 1(a) also include those groups that have self-nominated/registered and have met the satisfactory reporting criteria for the PQRS incentive payment.

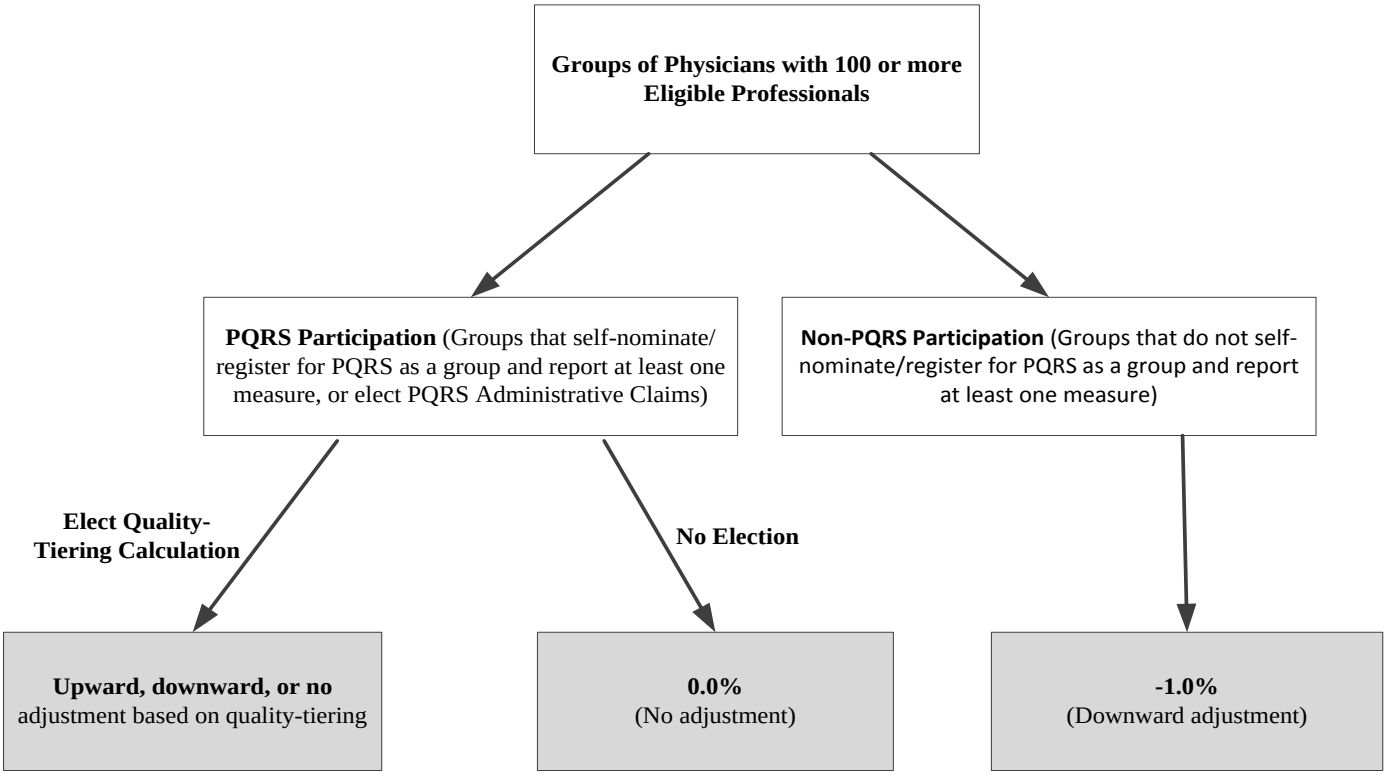
- For those groups of physicians within Category 1 that have elected to have their Value Modifier based on quality-tiering and have either met the satisfactory reporting criteria for the PQRS incentive or chose the PQRS Administrative Claims option:
    - We will use the performance rates on the quality measures reported through these reporting mechanisms (e.g., GPRO web-interface, CMS-qualified registry, or PQRS Administrative Claims option) and the three outcome measures (listed in Table 3) to calculate their Value Modifier.
    - Quality-tiering could result in an upward, downward, or no payment adjustment.

  For those groups of physicians within Category 1 that have elected to have their Value Modifier based on quality-tiering, but did not meet the satisfactory reporting criteria for the PQRS incentive, we will use the group's performance on the PQRS Administrative Claims measures for quality-tiering. Although the group self-nominated/registered and reported at least one measure, we would not have sufficient quality information to construct a quality composite under the quality-tiering approach.

- If the groups of physicians in Category 1 (both (a) and (b)) do not elect quality-tiering, then the Value Modifier will be 0.0 percent, meaning no payment adjustment will be applied to physicians in these groups for CY 2015.

(2) The second category includes those groups of physicians with 100 or more eligible professionals that do not fall within either of the two subcategories (a) and (b) of Category 1 described above. The Value Modifier for these groups of physicians will be -1.0 percent in CY 2015.

Figure 1: Overview of How CMS Calculates the Value Modifier for CY 2015



Individual PQRS Reporters: Physicians in groups of 100 or more eligible professionals that wish to report data for quality measures under the PQRS (Claims, CMS-qualified registry, or electronic health records (EHRs)) as individuals rather than as a group for the PQRS payment incentive must register for PQRS as a group and elect the PQRS Administrative Claims reporting mechanism by October 15, 2013. Such groups of physicians fall within Category 1(b) and avoid the Category 2 (-1.0 percent) downward Value Modifier payment adjustment. If the group elects quality-tiering, then calculation of the Value Modifier could result in an upward, downward, or no payment adjustment based on performance.

Table 1 shows how CY 2013 PQRS reporting by groups of physicians with 100 or more eligible professionals affects payment in CY 2015.

Table 1: PQRS Reporting by Groups of 100 or More Eligible Professionals during CY 2013 and the Impact on Payment During CY 2015

Group Self-Nomination/ Registration Action for CY 2013	Group Reporting Action for CY 2013	Individual Eligible Professional Reporting Action	Value Modifier Adjustment Effective January 1, 2015	PQRS Incentive for 2013 (paid in Fall of 2014)	PQRS Payment Adjustment Effective January 1, 2015
Self-nominates/ registers for PQRS GPRO	Meets criteria for PQRS incentive using the method for which it self-nominated/registered	N/A	0.0%* (for the group)	0.5% (for the group)	0.0% (for the group)
Self-nominates/ registers for PQRS GPRO	Submits only one PQRS measure	N/A	0.0% (for the group)	0.0% (for the group)	0.0% (for the group)
Self-nominates/ registers for PQRS GPRO	Does not meet the PQRS criteria for satisfactory reporting using the method for which the group self-nominated/registered	N/A	0.0% (for the group)	0.0% (for the group)	-1.5% (for the group)
Self nominates/ registers for PQRS GPRO	Does not submit PQRS measures	N/A	-1.0% (for the group)	0.0% (for the group)	-1.5% (for the group)
Registers for PQRS Administrative Claims	No Action	If individual's report separately they may be eligible to receive the PQRS incentive	0.0%* (for the group)	0.5% (only for the individual if they meet the individual reporting criteria)	0.0% (for the group)
Registers for PQRS Administrative Claims	No action	Individuals do not report separately for the PQRS incentive	0.0%* (for the group)	0.0% (only for the individual)	0.0% (for the group)
Does not self-nominate/ register for PQRS GPRO	N/A	Meets criteria for PQRS incentive as an individual	-1.0% (for the group)	0.5% (for the individual	0.0% (for the individual)

Group Self-Nomination/ Registration Action for CY 2013	Group Reporting Action for CY 2013	Individual Eligible Professional Reporting Action	Value Modifier Adjustment Effective January 1, 2015	PQRS Incentive for 2013 (paid in Fall of 2014)	PQRS Payment Adjustment Effective January 1, 2015
Does not self-nominate/ register for PQRS GPRO	N/A	Submits only one PQRS measure or does not meet the criteria for satisfactory reporting for PQRS incentive as an individual	-1.0% (for the group)	0.0% (for the individual)	0.0% (for the individual)
Does not self-nominate/ register for PQRS GPRO	N/A	Elects PQRS Administrative Claims option as an individual and does not report under any other reporting mechanism	-1.0% (for the group)	0.0% (for the individual)	0.0% (for the individual)
Does not self-nominate for PQRS GPRO	N/A	Does nothing	-1.0% (for the group)	0.0% (for the individual)	-1.5% (for the individual)

*If the group elects quality-tiering, then calculation of the Value Modifier could result in an upward, downward, or no payment adjustment based on performance.

(3) Quality-Tiering Election Process

To ease administrative burden and to align the quality-tiering election process with the self-nomination processes under the PQRS, we are using a web-based system for groups of physicians to elect the quality-tiering methodology. The system opens on July 15, 2013 and closes on October 15, 2013.

We want to emphasize that if a group of physicians with 100 or more eligible professionals does not self-nominate/register to participate in the PQRS GPRO (web-interface or CMS-qualified registry) or elect the PQRS Administrative Claims option for groups for PY 2013, its Value Modifier in CY 2015 will be -1.0 percent.

(4) Performance Period

CY 2013 is the initial performance period for the Value Modifier that will be applied in CY 2015. This means that we will use performance on quality and cost measures during CY 2013 to calculate the Value Modifier that will apply to items and services for which payment is made under the PFS during CY 2015.

Likewise, we will use performance on quality and cost measures in CY 2014 to calculate the Value Modifier that is applied to items and services for which payment is made under the PFS during CY 2016.

IV. PQRS Quality Reporting Mechanisms and Quality Measures

(1) Alignment of Quality Reporting Options with the PQRS

The groups of physicians with 100 or more eligible professionals must use the PQRS GPRO reporting mechanisms available to them (such as, web-interface or a CMS-qualified registry) or the PQRS Administrative Claims option as a group, for purposes of the 2015 Value Modifier.

In addition, if physicians in a group of physicians subject to the Value Modifier wish to report data for quality measures in the PQRS as individuals for the PQRS payment incentive rather than as a group practice, the group must elect the PQRS Administrative Claims reporting mechanism as a group by October 15, 2013. Such groups of physicians fall within Category 1(b) and avoid the Category 2 (-1.0 percent) downward Value Modifier payment adjustment. If the group elects quality-tiering, then calculation of the Value Modifier could result in an upward, downward, or no payment adjustment based on performance.

(2) Quality Measure Alignment with the PQRS

We finalized all of the individual measures under the PQRS for 2013 and beyond for the Value Modifier. These measures are listed in Tables 94, 95, 123, and 124 of the CY 2013 Medicare PFS final rule.
Federal Register Vol. 77, No. 222 (November 16, 2012): 69209-69287.

(3) PQRS Measures for Eligible Professionals and Group Practices that Report Using Administrative Claims for the 2015 Payment Adjustment

For those groups and individuals electing the PQRS Administrative Claims option, we will calculate them at the single TIN level and apply the TIN's performance to the TIN and all its members.

We finalized 17 measures, comprised of 14 process and 3 outcome measures (2 of which are Prevention Quality Indicator (PQI) composite measures), for inclusion in the PQRS Administrative Claims option measure set. Tables 2 and 3 list the process and outcome measures, respectively.

Table 2: Process Measures for Eligible Professionals and Group Practices Who Report Using Administrative Claims for the 2015 PQRS Payment Adjustment

Measures for the Administrative Claims Options for 2015			
NQF Number	**Measure Title**	**Measure Steward**	**Domain of Care**
0576	**Follow-Up After Hospitalization for Mental Illness** Percentage of discharges for patients who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.	NCQA	Care Coordination

Measures for the Administrative Claims Options for 2015			
NQF Number	**Measure Title**	**Measure Steward**	**Domain of Care**
0022	**Use of High-Risk Medications in the Elderly: (a) Patients Who Receive At Least One Drug To Be Avoided** Percentage of patients ages 65 years and older who received at least one high-risk medication in the measurement year. **(b) Patients Who Receive At Least Two Different Drugs To Be Avoided** Percentage of patients 65 years of age and older who received at least two different high-risk medications in the measurement year.	NCQA	Patient Safety
0555	**Lack of Monthly INR Monitoring for Beneficiaries on Warfarin** Average percentage of 40-day intervals in which Part D beneficiaries with claims for warfarin do not receive an INR test during the measurement period.	CMS	Patient Safety
0577	**Use of Spirometry Testing to Diagnose COPD** Percentage of patients at least 40 years old who have a new diagnosis or newly active chronic obstructive pulmonary disease (COPD) who received appropriate spirometry testing to confirm the diagnosis.	NCQA	Clinical Care
0543	**Statin Therapy for Beneficiaries with Coronary Artery Disease** Medication Possession Ratio (MPR) for statin therapy for individuals over 18 years of age with coronary artery disease.	CMS	Clinical Care
0583	**Lipid Profile for Beneficiaries Who Started Lipid-Lowering Medications** Percentage of patients age 18 or older starting lipid-lowering medication during the measurement year who had a lipid panel checked within 3 months after starting drug therapy.	Resolution Health	Clinical Care
0053	**Osteoporosis Management in Women ≥ 67 Who Had a Fracture** Percentage of women 67 years and older who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the 6 months after the date of fracture.	NCQA	Clinical Care
0055	**Dilated Eye Exam for Beneficiaries ≤ 75 with Diabetes** Percentage of adult patients with diabetes aged 18-75 years who received a dilated eye exam by an ophthalmologist or optometrist during the measurement year, or had a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year.	NCQA	Clinical Care
0057	**HbA1c Testing for Beneficiaries ≤ 75 with Diabetes** Percentage of adult patients with diabetes aged 18-75 years receiving one or more A1c test(s) per year.	NCQA	Clinical Care
0062	**Urine Protein Screening for Beneficiaries ≤ 75 with Diabetes** Percentage of adult diabetes patients aged 18-75 years with at least one test nephropathy screening test during the measurement year or who had evidence existing nephropathy (diagnosis of nephropathy or documentation of micro albuminuria or albuminuria).	NCQA	Clinical Care
0063	**Lipid Profile for Beneficiaries ≤ 75 with Diabetes** Percentage of adult patients with diabetes aged 18-75 who had an LDL-C test performed during the measurement year.	NCQA	Clinical Care

Measures for the Administrative Claims Options for 2015			
NQF Number	**Measure Title**	**Measure Steward**	**Domain of Care**
0075	**Lipid Profile for Beneficiaries with Ischemic Vascular Disease** Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) from January 1– November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to measurement year, who had a complete lipid profile during the measurement year.	NCQA	Clinical Care
0105	**Antidepressant Treatment for Depression** Percentage of patients who were diagnosed with a new episode of depression and treated w i t h antidepressant medication and who remained on an antidepressant medication treatment for: (a) at least 84 days (12 weeks) and (b) 180 days (6 months).	NCQA	Clinical Care
0031	**Breast Cancer Screening for Women ≤ 69** Percentage of eligible women 40-69 who receive a mammogram in during the measurement year or in the year prior to the measurement year.	NCQA	Clinical Care

Table 3: Outcome Measures for Eligible Professionals and Group Practices Who Report Using Administrative Claims for the 2015 PQRS Payment Adjustment

NQF Number	Measure Title	Measure Steward	Domain of Care
N/A	**1. Composite of Acute Prevention Quality Indicators (PQIs)**	N/A	Care Coordination
0279	**Bacterial Pneumonia** The number of admissions for bacterial pneumonia per 100,000 population.	AHRQ	
0281	**UTI** The number of discharges for urinary tract infection per 100,000 population Age 18 Years and Older in a one year time period.	AHRQ	
0280	**Dehydration** The number of admissions for dehydration per 100,000 population.	AHRQ	
N/A	**2. Composite of Chronic Prevention Quality Indicators (PQIs)**	N/A	Care Coordination
	Diabetes Composite		
0638	**Uncontrolled diabetes** The number of discharges for uncontrolled diabetes per 100,000 population Age 18 Years and Older in a one year time period.	AHRQ	
0272	**Short Term Diabetes complications** The number of discharges for diabetes short-term complications per 100,000 Age 18 Years and Older population in a one year period.	AHRQ	
0274	**Long term diabetes complications** The number of discharges for long-term diabetes complications per 100,000 population Age 18 Years and in a one year time period.	AHRQ	

NQF Number	Measure Title	Measure Steward	Domain of Care
0285	**Lower extremity amputation for diabetes** The number of discharges for lower-extremity amputation among patients with diabetes per 100,000 population Age 18 Years in a one year time period.	AHRQ	
0275	**COPD** The number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	AHRQ	
0277	**Heart Failure** **Percent of the population with admissions for CHF.**	AHRQ	
N/A	**3. All Cause Readmission** The rate of provider visits within 30 days of discharge from an acute care hospital per 1,000 discharges among eligible beneficiaries assigned.	CMS	Care Coordination

(4) Calculation of Quality Measures for the Value Modifier using Quality-Tiering

For groups of physicians electing quality-tiering, we will use the performance rates for the measures reported through the selected PQRS reporting mechanism during self-nomination/registration. We will also calculate their performance on the three outcomes measures listed in Table 3.

V. Cost Measures

Section 1848(p)(3) of the Act requires us to evaluate costs, to the extent practicable, based on a composite of appropriate measures of costs. We adopted five per capita cost measures in the quality-tiering election for the Value Modifier:

- Total per capita cost
- Per capita cost for beneficiaries with four specific chronic conditions:
    - Chronic obstructive pulmonary disease (COPD),
    - Heart failure,
    - Coronary artery disease (CAD), and
    - Diabetes.

Total per capita costs include payments under both Part A and Part B, but do not include Medicare payments under Part D for drug expenses. We plan to submit the total per capita cost measures and the four chronic condition-focused per capita cost measures for NQF endorsement.

We will use at least a 60-day claims run-out with a completion factor from CMS' Office of the Actuary to calculate the total per capita costs for the measures. For the 2015 Value Modifier, the performance period for the per capita cost measures is CY 2013.

(1) Payment Standardization Methodology for Cost Measures

The statute requires us to calculate cost measures based on standardized Medicare payments to ensure fair comparisons of costs across geographic areas. CMS has developed a Medicare payment standardization methodology that excludes such geographic payment differences. The

methodology is updated annually to reflect any change in CMS payment systems.

(2) Risk Adjustment Methodology for Cost Measures

We will use the Hierarchical Condition Category (HCC) model to risk adjust the five per capita cost measures included in the 2015 Value Modifier. The HCC model is calibrated on Medicare fee-for-service beneficiaries and is accurate in predicting these costs. The HCC model is also updated regularly by CMS to reflect changes in treatment patterns and costs.

VI. Attribution of Quality and Cost Measures

Calculation of the PQRS administrative claims-based quality and cost measure performance rates requires us to attribute Medicare beneficiaries to groups of physicians. For the 2015 Value Modifier, we finalized an attribution approach based on the methodology used in the Medicare Shared Savings Program to assign a beneficiary to an ACO. This methodology is described at http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf and 42 CFR §425.400 through §425.402. This attribution approach involves a two-step process that is based on the group that provides the plurality of primary care services to the beneficiary. Primary care services include office-based, home health, or nursing home evaluation and management codes as well as other codes defined by CMS. We define "primary care services" in 42 CFR §425.20 to mean the set of services identified by the following HCPCS codes: 99201 through 99215, 99304 through 99340, 99341 through 99350, G0402 (the code for the Welcome to Medicare visit), G0438 and G0439 (codes for the annual wellness visits).

- We note that certain large single specialty groups – such as those limited to emergency medicine, diagnostic radiology, pathology, and anesthesiology – may not be attributed any beneficiaries under this attribution methodology. Therefore, if one of these specialty groups with 100 or more eligible professionals elects quality-tiering, and the group is not attributed any beneficiaries, then their payment would not be adjusted. These groups, however, must still participate in the PQRS as described above to avoid the -1.0% Value Modifier downward payment adjustment.

VII. Composite Scores for the Value Modifier using Quality-Tiering

Section 1848(p)(2) of the Act requires that quality of care be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished. Likewise, section 1848(p)(3) of the Act requires that costs in the Value Modifier be evaluated, to the extent practicable, based on a composite of appropriate measures of costs. For groups of physicians electing the quality-tiering approach, we will use the following approach:

(1) Quality of Care and Cost Domains

Quality of Care Domains: We will align the quality measures reported by the groups of physicians, in addition to the three PQRS administrative claims-based outcome measures, with the six national priorities related to clinical care, patient experience, population/community health, patient safety, care coordination, and efficiency established in the National Quality Strategy.

We will classify each of the quality measures into one of these six domains. We will then weight each domain equally to form a quality of care composite. Within each domain, we will weight each measure equally so that groups of physicians have equal incentives to improve care delivery on all measures.

To the extent that a domain does not contain quality measures, the remaining domains would be equally

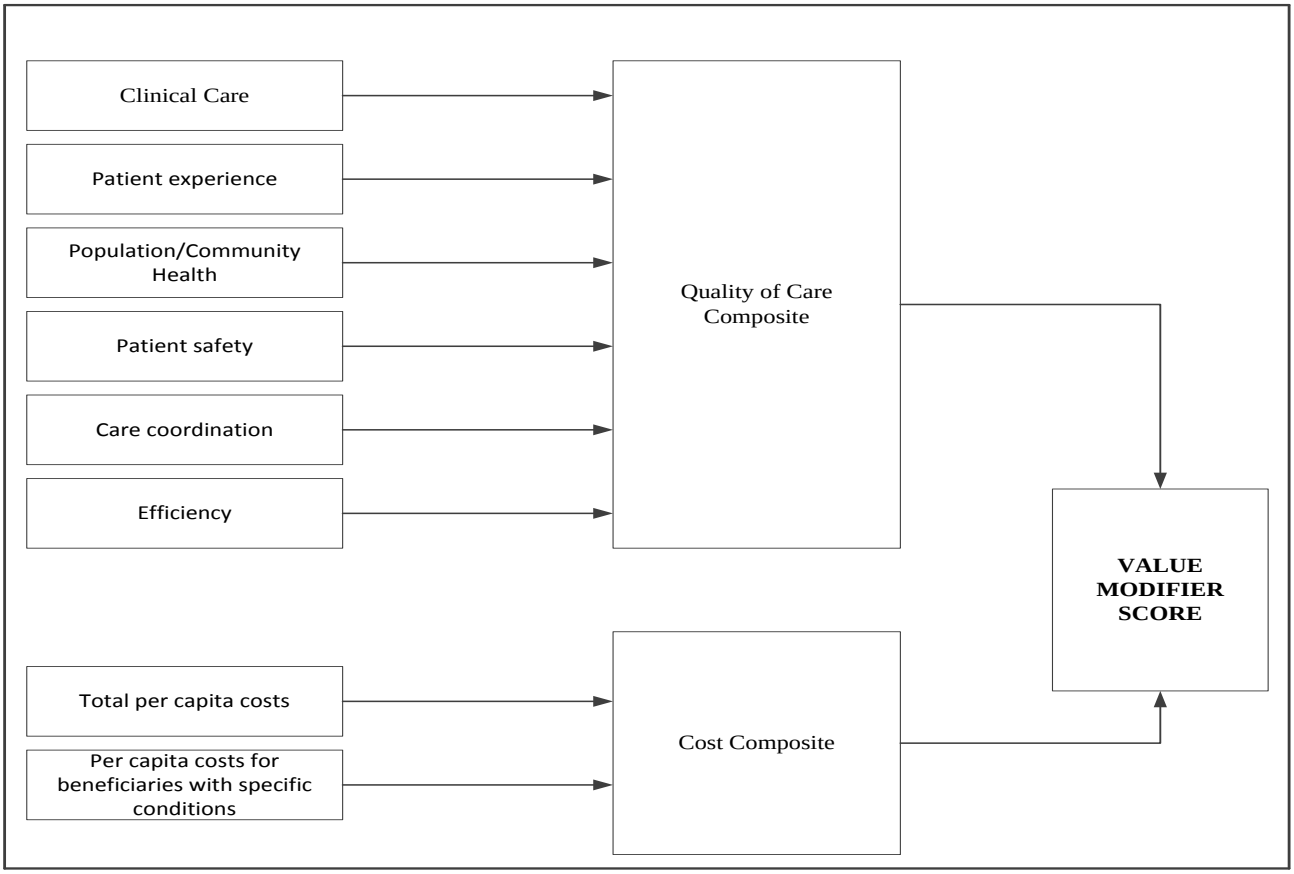
weighted to form the quality of care composite. For example, if only three domains contain quality information, each domain would be weighted at 33.3 percent to form the quality composite while the remaining three domains would not be included.

Cost Domains: We will use the five per capita cost measures: total per capita costs (Parts A and B) and total per capita costs for beneficiaries with four chronic diseases (diabetes, CAD, COPD, and heart failure). We will group these five per capita cost measures into two separate domains: total overall costs (one measure) and total costs for beneficiaries with specific conditions (four measures).

Similar to the quality of care composite, we will weight each cost domain equally to form the cost composite and within the cost domains we will weight each measure equally. In those instances in which we cannot calculate a particular cost measure, for example, due to too few cases, we will weight the remaining cost measures in the domain equally.

Figure 2 graphically depicts the policies for the quality of care and cost composites and how they relate to the Value Modifier.

Figure 2: Relationship between Quality of Care and Cost Composites and the Value Modifier



(2) Scoring Methods for Quality-Tiering

We will establish standardized scores for each quality and cost measure. This approach achieves our policy objective to distinguish clearly between high and low performance and it allows us to create composites of quality of care for groups of physicians that report different quality measures.

(3) Benchmarks and Peer Groups for Quality Measures

The benchmark for each quality measure will be based on the **national** mean of each measure's performance rate during the year **prior** to the performance year. For example, the benchmark for the 2013 performance year will be based on 2012. We will unify the calculation of the benchmark by weighting the performance rate of each physician and group of physicians submitting data (through any PQRS reporting mechanism) on the quality measure, regardless of specialty, by the number of beneficiaries used to calculate the performance rate.

In addition, the benchmarks for quality measures in the PQRS Administrative Claims reporting mechanism will be the national mean of each quality measure's performance rate calculated at the TIN level. We will calculate the national mean by including all TINs of groups of physicians with 100 or more eligible professionals. We will weight the TIN's performance rate by the number of beneficiaries used to calculate the quality measure. We also will use the year prior to the performance year as the year for calculating the benchmark. If a measure is new to the PQRS, we will be unable to calculate a benchmark, and therefore, performance on that measure will not be included in the quality composite.

(4) Benchmarks and Peer Groups for Cost Measures

To identify groups of physicians that are outliers (both high and low), we will use a cost attribution methodology that we use in the Medicare Shared Savings Program and that relies on a two-step process. See Section VI.

We will also establish **national** benchmarks for the five per capita cost measures based on data from the **current** performance year. Given that we are standardizing Medicare payments to eliminate regional payment differences, we do not believe it is appropriate to establish regional benchmarks for the Value Modifier.

(5) Reliability Standard

We will use a minimum case size of 20 in order for a quality or cost measure to be included in the quality of care or cost composite. To the extent that a group of physicians fails to meet the minimum number of cases for a particular measure, the measure would not be counted and the remaining measures in the domain would be given equal weight. To the extent that we cannot develop either a reliable quality of care composite or cost composite because we do not have reliable domain information, we would not calculate a Value Modifier for a group that chooses quality-tiering, and the group's payment would not be affected.

VIII. Quality-Tiering Scoring Methodology

The quality-tiering model compares the quality of care composite with the cost composite to determine the Value Modifier for those groups of physicians that elect quality-tiering. To make this comparison, we will classify the quality of care composite scores and the cost composite score into high, average, and low categories. To do so, we will first ensure that we measure the quality of care and cost composites precisely, namely at the 5.0 percent level of significance (i.e., a 95 percent confidence interval). If the composites are measured precisely, we will classify into high and low categories those composite scores that are at least one standard deviation above and below the mean, respectively.

We will then compare quality of care composite classification with the cost composite classification to determine the Value Modifier adjustment according to the amounts in Table 4.

Table 4: Value Modifier Amounts for the Quality-Tiering Approach

Quality/cost	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Average quality	+1.0x*	+0.0%	-0.5%
Low quality	+0.0%	-0.5%	-1.0%

* Eligible for an additional +1.0x if (1) reporting quality measures via the web-interface or CMS-qualified registry, and (2) average beneficiary risk score is in the top 25 percent of all risk scores.

Calculation of the upward payment adjustment factor (x): In order to ensure budget neutrality, we will first aggregate the downward payment adjustments in Table 4 with the -1.0% downward payment adjustments for groups of physicians subject to the Value Modifier that fall within Category 2 (described above). Using the total downward payment adjustment amount, we will then solve for the upward payment adjustment factor (x). These calculations will be done after the performance period has ended.

For example, after determining the aggregate projected amount of the downward payment adjustments, CMS could calculate that the payment adjustment factor (x) would be 0.75 percent such that high quality/low cost groups of physicians would receive a 1.5 percent (2 x 0.75) upward payment adjustment during the payment adjustment period.

Additional payment for treating high-risk beneficiaries: This scoring methodology will also provide a greater upward payment adjustment (+1.0x) for groups of physicians that care for high-risk patients (as evidenced by the average HCC risk score of the attributed beneficiary population) and submit data on PQRS quality measures through PQRS via the GPRO using the web-interface or CMS-qualified registry. We will increase the upward payment adjustment to +3x (rather than +2x) for groups of physicians classified as high quality/low cost and to +2x (rather than +1x) for groups of physicians that are either high quality/average cost or average quality/low cost if the group of physicians' attributed patient population has an average risk score that is in the top 25 percent of all beneficiary risk scores. In other words, this additional upward payment adjustment (+1.0x) will not apply to groups of physicians that select the PQRS Administrative Claims reporting mechanism.

IX. Physician Feedback Reports

(1) Overview

We intend to produce and disseminate Physician Feedback reports (also known as Quality and Resource Use Reports) in the fall of 2013 at the TIN level to all groups of physicians with 25 or more eligible professionals based on 2012 data. These reports will include a "first look" at the methodologies we finalized for the Value Modifier. We view these reports as a way to help educate groups of physicians about how the Value Modifier could affect their payment under the PFS. These reports will be made available in September 2013, to allow groups of physicians to make informed decisions regarding the selection of their 2013 PQRS reporting mechanism and whether to elect quality-tiering to calculate the Value Modifier.

In the fall of 2014, we will disseminate Physician Feedback reports containing CY 2013 data to groups of physicians subject to the Value Modifier. These reports will be the basis of the Value Modifier in 2015. These reports will contain, among other things, the quality and cost measures and measure performance and benchmarks used to score the composites, quality of care and cost composite scores, and the Value Modifier amount.

Table 5 shows the timeline for the Value Modifier that applies to payments for physicians in groups of 100 or more eligible professionals starting January 1, 2015.

Table 5: Timeline for the Value Modifier that Applies to Payments for Physicians in Groups of 100 or more Eligible Professionals Starting January 1, 2015

2013	2014	2015
December 1, 2012 - January 31 • Self-nominate for PQRS GPRO • Select a PQRS GPRO reporting mechanism (web interface or CMS-qualified registry) for PY 2013 **July 15 – October 15** • Register for PQRS GPRO • Select a PQRS GPRO reporting mechanism (web interface, CMS-qualified registry, or Administrative Claims option) for PY 2013 • NOTE: A group that self-nominated during the first period will be able to change its PQRS reporting mechanism during the second period • Elect quality-tiering approach to calculate the Value Modifier **Mid-September** • Retrieve 2012 Physician Feedback report	**1st Quarter** • Complete submission of 2013 information for PQRS **3rd Quarter** • Retrieve 2013 Physician Feedback report	**January 1** • Value Modifier applied

(2) Informal Review and Inquiry Process

After the dissemination of the Physician Feedback reports in the fall of 2014, physicians may e-mail or call a technical help desk to inquire about their report and the calculation of the Value Modifier. We have adopted this process to help educate and inform physicians about the Value Modifier, especially for those groups of physicians that have elected to have their Value Modifier calculated using a quality-tiering approach.