Update on Medicare’s Physician Incentive Programs

An Overview of the Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBPM), and Electronic Prescribing (eRx) Incentive Program

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Introduction

Overview

The Medicare Physician Incentive Programs

Across the last decade, CMS has developed and implemented several physician fee schedule incentive programs in an effort to monitor care consistency across providers, improve Medicare quality, and lower costs for beneficiaries. Providers have traditionally received financial incentives for reporting professional services and quality measures to CMS—although, as the programs develop, the agency is beginning to phase in financial penalties for noncompliance. The most recent changes to these physician incentive programs were included in the 2013 Medicare Physician Fee Schedule (MPFS) final rule, announced in November 2012, which updated these programs to better align with regulatory mandates, CMS’s programmatic observations, and provider feedback.

This white paper provides an overview of three Medicare physician incentive programs: the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VBPM), and the Electronic Prescribing (eRx) Incentive Program. It reviews the basic requirements of each program, examines their recent updates, and offers insight into the key implications these developments will have for providers.

A fourth program, the Medicare and Medicaid Electronic Health Records (or EHR) Incentive Program (commonly referred to as the meaningful use program) is not addressed in this white paper, due to separate eligibility and participation requirements. For extensive information on this program, Roundtable members are encouraged to access dedicated resources through The Advisory Board Company’s IT Strategy Council.

Eligible Professionals and Participation Options

To participate in PQRS, VBPM, or the eRx Incentive Program, providers must first qualify as “eligible professionals” (EPs) according to CMS’s definition. In these cases, the term “eligible professional” applies to participating Medicare physicians, mid-level practitioners (such as nurse practitioners and physician assistants), physical or occupational therapists, qualified speech-language pathologists, and qualified audiologists.

Please note, providers who are not paid under the Physician Fee Schedule (like those working in federally qualified health centers or rural health clinics) are not included in these three programs.

There are two ways for EPs to participate in the programs. The first is to participate as an individual under the individual reporting option, which does not require preregistration with CMS. The second is to participate as part of a group practice under the group practice reporting option (GPRO). CMS defines a “group practice” as having one Tax Identification Number (TIN) and two or more active EPs who have reassigned billing rights to that TIN. Group practices must self-nominate to CMS in order to obtain approval to participate and receive an assigned set of Medicare beneficiaries for each program.

Reporting Periods for Incentive Payments

The finalized reporting period for all programs is 12 months, which begins January 1 and ends December 31. Under PQRS, there is one exception - a six-month reporting period for incentives that is discussed more fully in the section entitled “Guidelines for Reporting PQRS Measures.” The eRx Incentive Program also features a second optional six-month reporting period.

Updated Reporting Mechanisms

Traditionally, individual EPs have been able to report quality measures via the following mechanisms:

1. Claims-based reporting, which requires EPs to submit the appropriate PQRS quality data codes (QDCs) on their Medicare Part B claims;

2. Registry-based reporting, which requires a legal arrangement with a qualified registry that allows for the disclosure and receipt of patient-specific data to CMS;

3. EHR-based reporting, through direct EHR-based reporting or EHR data submission vendors.
In the 2013 final rule, CMS introduced a new “administrative claims” reporting option (outlined below). Group practices, which were previously required to report via a web interface, can now also report via registry and administrative claims. Further detail on group reporting is available on [CMS's website](#).

**Physician Quality Reporting System (PQRS)**

Overview of PQRS Incentive Payments

CMS implemented the Physician Quality Reporting Initiative (PQRI) under the Tax Relief and Health Care Act of 2006. In 2011, the program became a permanent feature rather than a temporary initiative and was renamed the Physician Quality Reporting System (PQRS). PQRS establishes financial incentives and penalties for eligible professionals based upon their ability report data on quality measures (selected from a predetermined list) to CMS for professional services furnished under Medicare Part B.

Currently, PQRS allocates incentives and penalties solely based on whether EPs successfully submit a report and not on quality-related outcomes. As a result, as long as EPs satisfactorily report the required quality measures, they can earn a full incentive payment. To fulfill the requirements of PQRS, participating providers must choose the measures they wish to report, select a reporting period and reporting option, document patient visits, and finally submit their data to CMS. Once they have submitted this information, there are three possible outcomes:

1. If CMS deems the submission “satisfactory,” then the provider (or group) receives an incentive payment.
2. If the submission is not “satisfactory” but nevertheless does meet the minimum bar for participation—set in the 2013 final rule as successful reporting performance on one measure—the provider’s payment is not altered (they will receive neither an incentive nor a penalty).
3. If the provider fails to participate in PQRS at all, then he or she will be subject to a downward payment adjustment.

**Incentive Payment and Payment Adjustments Based on 2013 Participation**

The 2013 Medicare Physician Fee Schedule (MPFS) finalized an incentive payment of 0.5% of an EP’s total allowed charges for services to be paid in the year following the reporting period for satisfactory participation in PQRS. This will be the final year that this reporting incentive is offered under PQRS.

After 2014, reporting bonuses will be replaced by “payment adjustments”—penalties administered to subsequent Medicare reimbursement. Although providers will not be penalized for non-reporting until 2015, the data used to assign those penalties will be collected during the 2013 reporting period. Thus, *EPs who do not participate in PQRS in 2013 will be subject to a negative 1.5% penalty in 2015.*

**Delays Between Reporting Period and Incentive Payments, Adjustments**

*Incentive Payments Lag One Year, Adjustments Lag Two Years*

<table>
<thead>
<tr>
<th>Reporting Year</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incentive Payment Year</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>1.0%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>2.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adjustment Impact Year</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>(1.5%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>(2.0%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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Guidelines for Reporting PQRS Measures

Individual Reporting Option Mechanisms and Requirements

Reporting mechanisms differ depending on whether an EP chooses to participate under the individual reporting option or GPRO. Those who elect the individual reporting option may submit data on select measures or measures groups through a claims-, registry-, or EHR-based reporting system. Each individual measure corresponds to a specific clinical procedure. A “measures group” is a set of four clinically related measures, which may only be submitted via claims- or registry-based reporting.

### 2013 PQRS Measures Sets for Individual Reporting

<table>
<thead>
<tr>
<th>Measure set</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Measures</td>
<td>212</td>
</tr>
<tr>
<td>Measures Groups</td>
<td>26</td>
</tr>
</tbody>
</table>

PQRS follows a 12-month reporting period, with the exception of the registry-based reporting option, which features an optional six-month reporting period. Specific requirements for reporting individual measures and measures groups are listed in the table below.

### CMS Introduces New Reporting Option for 2013

In its most recent final rule, CMS finalized a new administrative claims-based reporting option for 2013. This method is similar to claims-based reporting except that participating organizations will have their claims analyzed by CMS, dramatically easing their reporting burden.

Interested providers will need to elect to participate in this program by October 15, 2013, either through CMS’s website or when they self-nominate for the GPRO. Because this program is intended as a temporary way to boost PQRS participation, groups that elect this option will not be eligible for an incentive payment. In addition, providers electing this reporting option should be aware that it has only been finalized for the 2013 reporting period and may not be available in subsequent years.

### PQRS Individual Reporting Options for 2013 Incentive

<table>
<thead>
<tr>
<th>Reporting Mechanism</th>
<th>Individual Measures</th>
<th>Measures Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claims-based</strong></td>
<td>• Report at least 3 individual measures</td>
<td>• Submit at least 1 measures group</td>
</tr>
<tr>
<td></td>
<td>• Report at least 50% of applicable patients</td>
<td>• Report at least 20 Medicare Part B patients</td>
</tr>
<tr>
<td></td>
<td>• 12-month reporting period</td>
<td>• 12-month reporting period</td>
</tr>
<tr>
<td><strong>Administrative claims-based</strong></td>
<td>• Not eligible for incentive</td>
<td>• Not eligible for incentive</td>
</tr>
<tr>
<td><strong>Registry-based</strong></td>
<td>• Submit at least 3 individual measures</td>
<td>• Submit at least 1 measures group during 12-month reporting period</td>
</tr>
<tr>
<td></td>
<td>• Submit data on at least 80% of applicable patients</td>
<td>– Report at least 20 patients, of which 50% must be Medicare part B</td>
</tr>
<tr>
<td></td>
<td>• 12-month reporting period</td>
<td><strong>6-month reporting period (July 1-Dec 31)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Report at least 20 patients, of which 50% must be Medicare part B</td>
</tr>
<tr>
<td><strong>EHR-based</strong></td>
<td>• Report at least 3 applicable individual measures</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>• EHR submits data on at least 80% of applicable patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 12-month reporting period</td>
<td></td>
</tr>
</tbody>
</table>
It is important to note that eligible professionals can only receive one incentive payment for participating in PQRS, regardless of if they satisfactorily report under two or more reporting mechanisms. Therefore, individual providers are advised to focus their efforts on reporting through one mechanism to ensure that all the necessary requirements are met and measures are reported upon successfully.

Group Practice Reporting Option (GPRO) Mechanisms and Requirements

As of 2013, groups of two or more eligible professionals using a single Tax Identification Number (TIN) that self-nominate as a GPRO can report PQRS measures via web-, registry-, and administrative claims-based methods. CMS plans to allow group practices to report PQRS measures through their EHRs, much like individual EPs can. However, because CMS wishes to make sure that this reporting option properly aligns with its meaningful use (MU) incentive program, it will not be available until 2014 at the earliest. As a result, groups that are interested in avoiding penalties in 2015 must make sure to successfully report at least one applicable measure to CMS during the 2013 reporting period using one of the reporting methods below.

**PQRS GPRO Reporting Options for 2013 Incentive**

<table>
<thead>
<tr>
<th>Reporting Mechanism</th>
<th>Group Practice Size</th>
<th>Reporting Requirements</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web-based</td>
<td>2-99 EPs</td>
<td>• Report on all measures included in web-interface</td>
<td>• Report up to 218 consecutive, confirmed, and completed beneficiaries for each disease module</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Report for pre-populated beneficiary sample</td>
<td>• Report preventive care measures</td>
</tr>
<tr>
<td></td>
<td>100+ EPs</td>
<td>• 12-month reporting period</td>
<td>• Report up to 411 consecutive, confirmed, and completed beneficiaries for each disease module</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Report preventive care measures</td>
</tr>
<tr>
<td>Registry-based</td>
<td>2+ EPs</td>
<td>• Report at least 3 measures</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Submit data on at least 80% of applicable patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 12-month reporting period</td>
<td></td>
</tr>
<tr>
<td>Administrative claims-based</td>
<td>2+ EPs</td>
<td>• Not eligible for incentive</td>
<td>• Not eligible for incentive</td>
</tr>
</tbody>
</table>

If a participating group does not meet the required number of assigned beneficiaries for any disease module or preventive care measure, the group must report 100% of eligible beneficiaries for that disease module or preventive care measure.

It is extremely important to remember that provider organizations interested in participating in PQRS’ Group Practice Reporting Option in 2013 will need to self-nominate for the GPRO by October 15, 2013. If a group practice fails to self-nominate by this date, it will be subject to a negative payment adjustment in 2015. Only groups that elect to report via the administrative claims-based method are exempt from this requirement.
**Additional Bonus Available Under PQRS**

CMS continues to offer its Maintenance of Certification (MoC) Incentive Program. This program provides board-certified professionals with an opportunity to earn an additional incentive payment of 0.5% of total allowed charges through PQRS by participating in a qualified MoC program “more frequently,” or at least once more, than required for certification. CMS is allowing flexibility in the interpretation of “more frequently” since frequency is dependent upon specialty and must be determined in relation to its designated requirements. Overall, CMS is seeking to reward providers who stay abreast of advances in their field and continue to advance their clinical capabilities.

Providers must participate in a Maintenance of Certification program for one year and successfully complete the MoC practice assessment. The Maintenance of Certification program must attest to the provider’s completion of both the MoC program and the practice assessment at least once more than is required by the specific MoC program.

Eligibility for the MoC incentive is contingent upon participation in PQRS. By participating in both programs, the total potential 2013 bonus increases to 1% of total allowed charges. Similar to the straight PQRS incentives, MoC incentives are currently scheduled only through 2014.

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**Value-Based Payment Modifier (VBPM)**

**Value-Based Payment Modifier Rewards High-Quality, Low-Cost Care**

CMS has finalized 2015 as the first year of its Value-Based Payment Modifier (VBPM) program. This program, mandated by the Affordable Care Act, will assign a “modifier” to each eligible provider (or provider organization). This modifier will adjust every provider’s Medicare reimbursement up or down based on that provider’s ability to deliver high-quality, lower-cost care. Providers that self-nominate as a group will see their reimbursement modified based upon their group’s performance. Those that are able to deliver high value care will see their reimbursement increase while those that lag behind in cost and quality will see their reimbursement lowered. Ultimately, CMS hopes that the incentives this program creates will help improve patient outcomes while reducing Medicare costs.

Although these value-based modifiers will not be assigned until 2015, because they will be calculated based on 2013 performance data reported through PQRS, it is important for physician groups to begin thinking about the program now.

**Timeline for 2015 Value Based Payment Modifier**

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1 – Oct. 15, 2013</td>
<td>Second opportunity to self-nominate for PQRS GPRO</td>
</tr>
<tr>
<td>First Quarter 2014</td>
<td>Complete submission of 2013 information for PQRS</td>
</tr>
<tr>
<td>January 1, 2015</td>
<td>Value-Based Payment Modifier Applied</td>
</tr>
</tbody>
</table>

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Who Will Be Affected

The VBPM program will not be applied to all providers at the same time. Instead, CMS is focusing on rolling the program out over a three-year window—from 2015 to 2017—in order to prepare providers for the transition. In 2015, CMS will assign a value-based modifier only to “qualified practices”—groups with 100 or more eligible provider (EPs). This is a notable change from the agency’s initial proposal to apply modifiers to all groups of 25 or more EPs.

Because CMS is required by the Affordable Care Act to apply a VBPM to all providers by 2017, providers should expect the VBPM program to expand rapidly over the next few years. The only physicians who will be exempted from receiving a modifier are those who are not paid under the Physician Fee Schedule (e.g., because they work at a Federally Qualified Health Center) and, at least for 2015 and 2016, physicians engaged in one of the following: the Medicare Shared Savings Program, the Pioneer ACO model, and the Comprehensive Primary Care Initiative.

Expansion of the Value-Based Payment Modifier

2015 – 2017

Impact on Qualified Practices

Qualified practices should remember that the modifier they will be assigned in 2015 will be based on the performance metrics they report to CMS through the PQRS program in 2013. As a result, provider organizations interested in succeeding under the VBPM program will need to both participate in PQRS as a group (taking care to either self-nominate under the GPRO or elect the administrative claims option) and carefully consider their performance on the required reporting metrics.

As the table below illustrates, qualified practices that do not participate in PQRS will automatically be assigned a VBPM of negative 1% (reducing their 2015 Medicare reimbursement by 1% in addition to the negative 1.5% penalty that they will receive for not participating in the PQRS program). Groups that participate in PQRS can choose to be assigned a VBPM of 0% (leaving their reimbursement unaltered) or elect CMS’s quality-tiering option.

Financial Impact of the 2015 Value-Based Payment Modifier

Based on 2013 PQRS Performance Data

<table>
<thead>
<tr>
<th></th>
<th>PQRS Non-participant</th>
<th>PQRS Participant</th>
<th>PQRS Participant Quality-Tiering</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Upside</strong></td>
<td>0.0%</td>
<td>0.0%</td>
<td>Unknown</td>
</tr>
<tr>
<td><strong>Downside</strong></td>
<td>(1.0%)</td>
<td>0.0%</td>
<td>(0.5%) or (1%)</td>
</tr>
</tbody>
</table>
Quality-Tiering

Qualified practices participating in PQRS can elect to receive a “quality-tiered” VBP modifier. Those that do so will receive a positive or negative change to their Medicare reimbursement update based on their ability to deliver high-quality, low-cost care relative to the other groups that have elected quality-tiering.

Low-performers who elect this option will be assigned payment modifiers of negative 0.5% or negative 1% while high-performers will see their reimbursement increase. Because the VBPM program is revenue neutral, the precise reimbursement increases that high-performers receive will depend on the total penalties levied on low performers. For a better sense of the possible payment adjustments under the quality-tiering option, please see the table below.

### Possible Financial Outcomes Under Quality-tiering

| Percentage Value
<table>
<thead>
<tr>
<th>Low Cost</th>
<th>Average Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td>2.0x</td>
<td>1.0x</td>
</tr>
<tr>
<td>Average Quality</td>
<td>1.0x</td>
<td>0.0</td>
</tr>
<tr>
<td>Low Quality</td>
<td>0.0</td>
<td>(0.5)</td>
</tr>
</tbody>
</table>

As previously noted, the value of x depends on the total value of penalties that CMS assigns to low-performing organizations.

**Calculating the Quality-Tiered Payment Modifier**

For the purposes of quality-tiering, CMS will measure provider performance using 2013 physician data reported through PQRS. Each provider organization’s performance on these measures will be compared against other organizations that have elected quality-tiering and scored based upon how many standard deviations their performance data is from the mean.

Measures of cost will be determined by total per capita cost measures (under both Medicare Part A and Part B) and per capita cost measures for four chronic conditions—chronic obstructive pulmonary disease, coronary artery disease, heart failure, and diabetes—adjusted for geographic differences. In the future, CMS states it plans to develop a reliable and valid measure of value to differentiate payment, taking into account the diversity of patient conditions and physician practices.

Aware of the uncertainty that this may cause physicians, CMS is planning to contact practices that are qualified to receive a value-based payment modifier in mid-September of 2013 with a report outlining how their organization would have performed under quality-tiering (based on their 2012 PQRS data). These practices will then have a month to consider this information and decide whether to elect to participate in quality-tiering or not.

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**Electronic Prescribing (eRx) Incentive Program**

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized the Medicare Electronic Prescribing (eRx) Incentive Program to promote physician use of electronic prescribing systems. Beginning in 2009, eligible professionals could receive incentives and penalties based on their use of electronic media to transmit “prescription or prescription-related information between prescribers, dispensers, pharmacy benefit managers (PBMs), or health plans.” The program promotes the adoption and use of electronic prescribing systems by both individual providers and group practices. Individuals and groups must adopt a certified eRx system or certified EHR technology in order to participate.
Although most of the regulations surrounding the eRx program were established by CMS in prior years, the 2013 Medicare Physician Fee Schedule final rule clarified a few aspects of the program. Most notably, the final rule lowers the number of EPs required to participate in eRx under the GPRO from 25 to 2—allowing groups of between 2 and 24 EPs the option of reporting as a group. In addition, CMS has waived its traditional requirement that groups interested in the eRx GPRO submit a self-nomination statement for PQRS. As was the case previously, EPs who wish to report individually do not need to preregister with CMS.


**eRx Incentive Payments and Payment Adjustments**

Because the 2012 MPFS finalized the requirements for both incentive payments and payment adjustments through 2014, there were no changes to these amounts in the 2013 schedule. Successful participants will receive an incentive payment of 0.5% in 2013. Please note that the incentive payment for each year is based upon the same year’s 12-month reporting period, meaning that 2013 incentive payments will be determined by whether or not a provider has met the criteria for successful reporting between January 1, 2013, and December 31, 2013.

The reporting period that determines payment adjustments is less straightforward. Specifically, for each year of payment adjustments, there are two corresponding reporting periods: a six-month reporting period and a twelve-month reporting period. This gives providers two chances to successfully participate in eRx and avoid receiving a downward payment adjustment. If an EP or group practice does not submit electronic prescriptions during the six-month reporting period of a given year, or the twelve-month reporting period the previous year, they will face a penalty the following year. Thus, the 2014 penalty (negative 2%) will impact only those EPs who did not participate in eRx during either the six-month reporting period in 2013 or the twelve-month reporting period in 2012.

**eRx Incentives and Payment Adjustment Timeline**

- **Delayed Adjustments Variable Based upon Six- and Twelve-Month Reporting Periods**

<table>
<thead>
<tr>
<th>Reporting Year</th>
<th>Incentive Payment</th>
<th>Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>2.0%</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>1.0%</td>
<td>(1.0%)</td>
</tr>
<tr>
<td>2012</td>
<td>1.0%</td>
<td>(1.5%)</td>
</tr>
<tr>
<td>2013</td>
<td>0.5%</td>
<td>(2.0%)</td>
</tr>
<tr>
<td>2014</td>
<td>0.0%</td>
<td></td>
</tr>
</tbody>
</table>


Because both the six-month and the twelve-month reporting periods for the 2013 payment adjustment have already occurred, providers who have not been participating in eRx will not be able to avoid a negative 1.5% payment adjustment in 2013 unless they file for a significant hardship exemption (outlined on page 12). However, because the six-month reporting period for the 2014 payment adjustment (from January through July 2013) has not yet occurred, it is not too late for groups that are not currently participating in eRx to avoid receiving this negative 2% penalty in 2014.
Individual and Group Reporting Mechanisms and Requirements

During the twelve-month reporting period, EPs and group practices can participate in the eRx Incentive Program through one of the three reporting mechanisms—claims, registry, and EHR—however providers are only permitted to use the claims-based reporting during the six-month reporting period.

To receive an incentive payment, e-prescribing must be reported for patient visits that meet the appropriate coding criteria. There are 56 eligible CPT or HCPCS codes that denote eligible cases. For twelve-month reporting, a successful EP must report a minimum of 25 unique e-prescriptions. At least 10 of these visits must occur and be reported within the first six-month reporting period to avoid penalty.

Group practices must report for a minimum of 75, 625, or 2,500 unique visits, depending upon size. This 75-prescription option was added in the 2013 final rule to account for the expansion of the GPRO to groups of between 2 and 24 EPs. These minimum reporting requirements are the same for the six-month and twelve-month reporting periods.

eRx Reporting Periods and Corresponding Payment Adjustments

<table>
<thead>
<tr>
<th>Reporting Periods</th>
<th>Reporting Mechanism</th>
<th>Individual Reporting</th>
<th>GPRO (2 – 24 EPs)</th>
<th>GPRO (25+ EPs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-Month Reporting</td>
<td>Claims-based</td>
<td>10 electronic</td>
<td>75 electronic</td>
<td>25-99 EPs: 625 electronic prescriptions</td>
</tr>
<tr>
<td>12-Month Reporting</td>
<td>Claims-, Registry-, EHR-based</td>
<td>25 electronic prescriptions</td>
<td>100+ EPs: 2,500 electronic prescriptions</td>
<td></td>
</tr>
</tbody>
</table>

eRx Hardship Exemptions

In an attempt to ensure fairness across all potential prescribers, CMS will not penalize providers who do not ordinarily prescribe in high volumes. CMS also tries to ensure fairness by recognizing that not all providers have the financial or operational capacity to implement electronic prescribing systems. EPs who fall under these categories are eligible to submit hardship exemptions that will prevent them from being penalized for nonparticipation. CMS originally finalized four hardship exemptions in its 2012 final rule for providers that:

1) Practice in rural areas with limited access to internet
2) Practice in areas with limited pharmacies available for electronic prescribing
3) Are unable to electronically prescribe due to local, state, or federal regulation
4) Issue fewer than 100 prescriptions during a six-month payment adjustment period

In the 2013 rulemaking period CMS added two additional hardship exemptions for providers that:

5) Achieve meaningful use during the relevant six- or twelve-month eRx payment adjustment reporting periods.

Groups interested in this hardship exemption must demonstrate meaningful use of a Certified EHR Technology for a full 90-day EHR reporting period during either the six- or twelve-month eRx payment adjustment reporting periods.

6) Have demonstrated intent to participate in the EHR Incentive Program and adopt Certified EHR Technology.

CMS plans to monitor the efforts of groups that elect this hardship exemption in order to make sure that they deliver on their promise to participate in the EHR program.

Providers interested in filing for either of these final two hardship exemptions must do so by January 31, 2013, to avoid the 2013 payment adjustment—their last chance to do so. This deadline was set to best align the eRx program with the reporting requirements for meaningful use.
Four Key Implications of 2013 Program Updates

The recent revisions to CMS’s physician fee schedule incentive programs have been finalized to help CMS better monitor and improve the quality of care that Medicare beneficiaries receive. In previous years, changes to each of the Medicare physician incentive programs and their reporting requirements were influenced largely by the reporting results from prior years and CMS’s own observations regarding program efficiency. As a result, each program’s development occurred somewhat independently.

Recent updates to these programs have attempted to align their requirements to establish a central infrastructure that eases the reporting burden for providers and increases their participation. While revisions to PQRS, VBPM, and eRx may seem isolated and incongruous when viewed independently, analyzing these changes together reveals four common themes. CMS hopes these changes will increase provider participation, improve and streamline program alignment, expand program applicability, and improve physician performance transparency.

1) **Moving from Carrots to Sticks to Increase Provider Participation**

**Payment Penalties Create Urgency to Participate**

Even though provider participation has increased in both the PQRS and eRx programs over the past several years, most Medicare physicians are still not participating in these programs. CMS hopes that evolving from offering reimbursement incentives for participation to inflicting reimbursement penalties for nonparticipation will push more providers to participate in the programs. Since CMS intends to build the VBPM program off of PQRS-submitted data, CMS needs to drive up the percentage of EPs participating in PQRS in particular.

Though some providers may have viewed the small bonuses for these programs over the last few years as unworthy of pursuit relative to the cost of implementing a PQRS reporting or e-prescribing process, both of these programs have increasingly significant penalties rolling out over the next few years—creating a much more compelling reason for providers to participate if they have not done so already.

**Maximum Combined Incentives and Penalties for PQRS, MoC, eRx Incentive Programs**

<table>
<thead>
<tr>
<th>Year</th>
<th>PQRS</th>
<th>MoC</th>
<th>eRx</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>2.0%</td>
<td>1.0%</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>1.5%</td>
<td>1.0%</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>(1.0)%</td>
<td>(1.5)%</td>
<td>(2.0)%</td>
</tr>
<tr>
<td>2015</td>
<td>(1.5+)%²</td>
<td>(2.0+)%²</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>(2.0+)%²</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


2) Given that the penalties for eRx beyond 2014 have not yet been determined, it is possible that eRx payment adjustments will add to the penalties shown for PQRS.

2) **Working to Ease Participation, Reduce Reporting Burden**

Many of the recent changes to Medicare’s physician incentive programs helped foster increased program alignment and streamline program infrastructure, making it easier for EPs to participate and for CMS to administer all three programs.

Building on its decision to standardize the reporting periods for PQRS (with one optional exception for those engaging in registry-based reporting) in 2012, CMS has worked to better assist providers in their compliance efforts by offering more reporting options. In the 2013 rulemaking period, CMS expanded...
the number of practices eligible for the GPRO for both the PQRS and eRx programs (by reducing the required number of EPs from 25 to 2), restricted the number of practices eligible for the VBPM program in 2015 (this time by raising the required number of EPs from 25 to 100), opened up new hardship exemptions under its eRx program, and extended the yearly PQRS participation deadline to October 15.

Most notably, CMS took steps in its 2013 final rule to dramatically reduce the reporting burden for providers and provider groups interested in participating in PQRS. EPs who are interested in merely avoiding a penalty in 2015 only need to successfully report one performance measure to the agency in 2013—which is especially important for providers who might have previously found PQRS program participation challenging.

Providers who find even this reporting burden too onerous can select administrative claims-based reporting and have CMS analyze their data for them. Although these are both temporary measures designed to get providers in the habit of reporting performance data through the PQRS program, they nonetheless represent a concerted effort on the part of CMS to ease the burden on providers.

### Shared Savings Program Participation Includes PQRS

CMS added measures to the PQRS GPRO to better align with organizations pursuing the Medicare Shared Savings Program (MSSP). Eligible professionals within an MSSP accountable care organization (ACO) may earn incentives under the PQRS GPRO if they meet the minimum ACO quality standards. Since ACOs will be considered group practices under the PQRS GPRO, those eligible professionals will not have to participate in PQRS separately to avoid penalties under either PQRS or the VBPM program.

### 3) Expanding Program Applicability Across Providers

CMS frequently expands the list of measures available for reporting under each Medicare incentive program. In response to feedback from specialist providers in particular, recent fee schedule rules have placed additional emphasis on both addressing gaps across PQRS measure sets and promoting disease prevention and care coordination.

### Increasing PQRS Program Applicability across Various Specialties Still an Ongoing Effort

Many providers, especially hospital-based physicians (hospitalists, surgeons, sub-specialists, etc.), have submitted comments to CMS stating that previous PQRS measure sets lacked procedures on which they could report, attributing this limitation as a main reason for nonparticipation. Given that many of the measures are organized by disease modules (procedures relevant to the treatment of various medical conditions), CMS focused on expanding the measures within these modules in an attempt to improve the applicability of the lists. While CMS added a variety of new measures to all the PQRS measures sets (not including the measures from the EHR Incentive Program), there are still specialists who feel they are underrepresented. As the threat of penalties becomes more imminent, the urgency with which provider groups are requesting an expansion of the measure set is becoming stronger. CMS is continuing to accept suggestions for new measures.

### Bolstering Prevention and Primary Care

CMS continues to expand the set of PQRS measures for preventive and primary care services to meet the new demands being placed on providers by changing Medicare population demographics, such as the influx of baby boomers and increase in comorbidities.

In the 2012 MPFS proposed rule, CMS included a new set of seven “core measures” for PQRS aimed at the prevention of cardiovascular conditions. Examples of these core measures include controlling high blood pressure, performing cholesterol-LDL tests, and tobacco use assessment/intervention. The proposal required EPs in cardiology, general practice, family practice, and internal medicine to report on at least one of these measures. Even though this proposal was not finalized in 2012 due to CMS’s own operational limitations, CMS has stated that it plans on enacting this requirement in the future as primary and preventive care become more important. Relevant providers should begin reporting at least one of these core measures in preparation for this requirement, since future updates to the PQRS program will likely enact this requirement.

Providers need to successfully report only one performance metric in 2013 to avoid PQRS penalty

Trying to increase PQRS applicability to specialists, bolster prevention

Providers need to successfully report only one performance metric in 2013 to avoid PQRS penalty
4) Improving Physician Performance Transparency

Physician Performance Outcomes Available via Physician Compare Website

Over the past few years, CMS has created a variety of websites to allow Medicare beneficiaries to compare the performance of hospitals, nursing homes, dialysis facilities, and home health facilities. Mandated by the Affordable Care Act, Medicare is now extending this effort to physicians via the Physician Compare website.

Physician Compare currently exists as a provider directory, although CMS is required by law to update it to include quality data. As part of this effort, the 2013 MPFS finalizes CMS’s plans to make physician quality data publicly accessible to the public.

Given the robust data on quality measures collected through the PQRS GPRO reporting option, the website will begin to make PQRS GPRO data public no later than 2014. Quality measures reported by ACOs through GPRO will also be reported on Physician Compare. While CMS will initially attribute quality data to group practices, not individual providers, the agency has moved its time frame for posting individual provider level performance data forward by a year. Although this will be better defined in subsequent Medicare physician fee schedule final rules, providers should expect CMS to report their individual 2014 performance on PQRS quality measures in 2015.
Suggested Next Steps for Physician Practices

Five Lessons for Providers

**#1: Participate to Avoid Penalties, Maximize Incentives**

With penalties looming, there is little reason not to begin (or continue) participating in Medicare’s physician incentive programs. Not only has CMS determined that providers who have experience from prior years find reporting much easier, but the requirements for participation have been lowered to encourage new entrants. In fact, providers need only submit one performance measure to participate in programs PQRS. Of course, early participation also allows providers to access incentive payments before they phase out and, more importantly, to avoid Medicare reimbursement cuts in 2015.

It is particularly important that providers act quickly to avoid the 2014 payment adjustment posed by the eRx Incentive Program if they have not done so already. To avoid this penalty, non-participants will need to either successfully report their participation during the six-month 2013 reporting period or successfully qualify for one of the significant hardship exemptions outlined in this paper.

**#2: Review New Program Requirements to Ensure Reporting Success**

Even though the Medicare physician incentive programs share overarching guidelines, there are distinct differences in each program’s reporting requirements that must be observed. In addition, because certain measures may be more suitable for certain types of physicians to report than others, it is important for providers to take the time to review each program and determine the most appropriate reporting measures for their organization. CMS has estimated that providers will spend around five hours learning the requirements and selecting applicable measures for PQRS alone.

**#3: Leverage Program Overlap to Lessen Reporting Burden**

Individuals and groups seeking both PQRS and EHR (meaningful use) incentive payments should likely choose to report on the PQRS EHR-based measures that overlap with meaningful use quality measures. CMS incorporated the EHR-based measures to ease the reporting burden for providers pursuing both PQRS and EHR incentives.

**#4: Ensure High Quality, Low Cost of Care to Receive Medicare Pay-for-Performance Incentives**

As PQRS penalties and the value-based payment modifier go into effect, the pressure to provide high-value care is increasing. Beyond purely financial incentives, CMS has also put pressure on providers to deliver high-quality care through its Physician Compare website. Though the current focus of the Medicare physician incentive programs is still heavily weighted toward chronic and preventive measures, CMS’s gradual incorporation of specialty-specific and outcomes-oriented measures embodies the growing shift toward pay-for-performance incentives that will require a renewed focus on the highest standards of care delivery across the continuum. Under these new demands, not only will CMS monitor provider performance, it will also evaluate provider outcomes.

**#5: Wait Before Electing Quality-Tiering Option in VBPM Program**

The quality-tiering option contained within the Value-Based Payment Modifier program offers considerable uncertainty for physician practices. In an effort to ameliorate this, CMS pledged to contact physician practices of 100 or more EPs in mid-September 2013 to report what their performance would have been if they had participated in quality-tiering 2012 (based on their 2012 PQRS data). Groups will then have until October 15, 2013, to review this information and determine whether or not to participate. Because of this new information, we encourage qualified physician practices to wait and examine their September report before electing the quality-tiering option in the VBPM program.
Related Information

This white paper is part of a suite of resources that the Physician Practice Roundtable has developed to support independent physician organizations around Medicare payment updates and value-based care issues. For practice leaders interested in additional support, we recommend the following resources:

- **Archived Webconferences**
  - 2013 Medicare Physician Payment Update
  - 2013 Oncology Medicare Reimbursement Update
  - CMS’s Hospital Outpatient and Ambulatory Surgery Center Final Rule

- **Research and Topic Briefs**
  - Six Takeaways from the 2013 Medicare Physician Fee Schedule Final Rule
  - Frequently Asked Questions and Answers on Meaningful Use
  - Detailed Analysis of the Final Rule on Stage 2 of Meaningful Use
  - Meaningful Use Pocket Guide

Roundtable publications are available to members in unlimited quantity and without charge. Additional copies can be ordered at advisory.com/ppr or by contacting your institution’s Dedicated Advisor, Zane Greason (greasonz@advisory.com or 202-568-7037) or Kaylin Politzer (politzek@advisory.com or 202-266-6558).

Members are also encouraged to contact Program Director Teresa Breen at breent@advisory.com or 202-266-5675 with questions or feedback about the Physician Practice Roundtable’s resources.

Beyond the Physician Practice Roundtable

Introducing Crimson Care Registry

Looking for assistance with PQRS? Unsure which vendor to choose? Crimson Care Registry (CCR) is a qualified Physician Quality Reporting registry and can submit quality data to CMS for eligible professionals to help them earn their full incentives. CCR was vetted to validate the presence of the following:

- Ability to provide the required PRRS data elements
- Measure flows and algorithms that perform use case calculations
- Transmission of data in the requested XML file formats

What’s more, hundreds of practices—ranging from solo practitioners to federally qualified health clinics and health system physician-hospital organizations—use Crimson Care Registry to support physicians in making data-driven clinical decisions and to ensure patients are up-to-date on critical care needs. Crimson Care Registry can support Patient Centered Medical Home efforts and participation in the Medicare Shared Savings Program.

For more information on Crimson Care Registry, please contact your Dedicated Advisor.