



Centers for Medicare & Medicaid Services

2012 Physician Quality Reporting System

Town Hall Meeting Background Paper

February 9,
2011



Purpose

As the Physician Quality Reporting System (formerly the Physician Quality Reporting Initiative or PQRI) continues into its sixth year in 2012, CMS continues to seek ways to improve the program. The purpose of this Town Hall is to solicit input on:

- The individual quality measures and measures groups for possible inclusion in the proposed set of quality measures for use in the 2012 Physician Quality Reporting System program (for example, suggestions for new measures groups or suggestions for the composition of existing measures groups).
- Key components of the design of the Physician Quality Reporting System program, such as possible reporting mechanisms, reporting periods, criteria for satisfactorily reporting, the group practice reporting option (GPRO), Maintenance of Certification Program incentive, informal review process, and program design beyond 2012.

CMS will consider feedback from this Town Hall as it determines which program design changes and which individual measures and measures groups to include in the proposed set of 2012 Physician Quality Reporting System quality measures. CMS intends to publish the proposed Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program requirements for 2012 in the Calendar Year (CY) 2012 Medicare Physician Fee Schedule (PFS) proposed rule. After a period of public comment, CMS will make its determination with regard to the final Physician Quality Reporting System and eRx Incentive Program requirements and set of quality measures for 2012 and publish them in the CY 2012 PFS final rule.

This paper includes background on the Physician Quality Reporting System and eRx Incentive Program and key discussion questions about the program components and design considerations intended to elicit productive discussion of stakeholder suggestions as the agency deliberates issues concerning the 2012 program year.

Background

The Physician Quality Reporting System is a reporting program in which eligible professionals and group practices report data on quality measures to CMS. This program was initially implemented in 2007 as a result of section 101(b) of Division B – Medicare Improvements and Extension Act of 2006 of the Tax Relief and Health Care Act of 2006 (TRHCA), and further extended and enhanced as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), and the Affordable Care Act.

An eligible professional who satisfactorily reports data on quality measures may qualify to earn a Physician Quality Reporting System incentive payment for 2012 based on a percentage of the eligible

professional's total estimated allowed Medicare Part B charges for covered professional services furnished during a specified reporting period. Our goals for the 2012 Physician

Quality Reporting System include increasing participation in light of a payment adjustment that begins in 2015, leveraging the benefits of alternative reporting mechanisms, such as registry based reporting, EHR-based reporting, and the group practice reporting option, and increasing alignment with other programs, such as the EHR Incentive Program.

Under section 1848(k)(3)(B) of the Social Security Act (the Act), the following professionals are eligible to participate in the Physician Quality Reporting System:

- Medicare Physicians
- Doctors of Medicine
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Doctor of Optometry
- Doctor of Oral Surgery
- Doctor of Dental Medicine
- Doctor of Chiropractic
- Practitioners
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant)
- Certified Nurse Midwife
- Clinical Social Worker
- Clinical Psychologist
- Registered Dietician
- Nutrition Professional
- Audiologists
- Therapists
- Physical Therapist
- Occupational Therapist
- Qualified Speech-Language Therapist

Visit the CMS Physician Quality Reporting System website at <http://www.cms.hhs.gov/PQRI> for more information on which professionals are eligible to participate in the Physician Quality Reporting System.

Since its inception, the Physician Quality Reporting System has grown from a claims-based only quality measures reporting program with 74 quality measures available for reporting in 2007, to a

program with more than twice as many quality measures and several different reporting options from which an eligible professional can select. Eligible professionals participating in the 2011 Physician Quality Reporting System can choose to report via claims, a qualified registry, or a qualified EHR to qualify for an incentive equal to 1.0 percent of their total estimated Medicare Part B PFS allowed charges for covered professional services furnished during the applicable 2011 reporting period. Alternatively, eligible professionals in group practices can qualify for an incentive equal to 1.0 percent of the group practice's total estimated Medicare Part B PFS allowed charges for covered professional services furnished during the 2011 reporting period via one of two group practice reporting options (GPRO I & II). Eligible professionals (or group practices) who satisfactorily report data on quality measures for covered PFS services furnished to Medicare Part B beneficiaries will qualify to earn a 2012 incentive payment of 0.5%.

In addition, through 2014, physicians who satisfactorily report Physician Quality Reporting System measures for a year may receive an additional 0.5 percent incentive payment for that year when they “more frequently” than is required to qualify for or maintain board certification status (1) participate in a Maintenance of Certification Program and (2) complete a qualified Maintenance of Certification Program practice assessment.

Discussion Questions

Measures

Reporting specified data on quality measures is the foundation of the Physician Quality Reporting System. Each year, an essential step in planning the Physician Quality Reporting System program is the consideration and selection of potential individual measures and measures groups for inclusion in the next program year, based on established criteria. With the broad array of clinical specialties and care settings in which eligible professionals practice, the selection of measures for inclusion in the Physician Quality Reporting System is a complex undertaking. Section 1848(k)(2)(D) of the Act requires that, for the 2010 Physician Quality Reporting System and subsequent program years, for each quality measure adopted, the Secretary shall ensure that the eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish. To satisfy this requirement with respect to the selection of 2012 Physician Quality Reporting System measures, CMS intends to publish a proposed set of quality measures for the 2012 Physician Quality Reporting System in the Federal Register via the CY 2012 PFS proposed rule with comment period.

In the CY 2011 PFS proposed rule (75 FR 73490 through 73610), CMS announced its intention to solicit suggestions for individual measures and measures groups including suggesting new measures or measures groups and suggestions for the composition of existing measures groups for possible inclusion in the proposed set of 2012 Physician Quality Reporting System quality measures. Toward this end, CMS conducted the “2012 Physician Quality Reporting System Call for Measures,” which was posted on the CMS Web site at http://www.cms.gov/MMS/13_CallForMeasures.asp#TopOfPage.

CMS requested that respondents provide certain information so that CMS would have sufficient measure specification information for each suggested measure in order for CMS to properly consider each suggestion. This “2012 Physician Quality Reporting System Call for Measures” was announced to the public through CMS’ standard communication channels, such as the Physician Quality Reporting System National Provider Calls and listserv messages. The deadline for submitting quality measures suggestions in response to the “2012 Physician Quality Reporting System Call for Measures” was Friday, December 17, 2010, 5:00 p.m. E.S.T.

In its publication of the 2012 Physician Quality Reporting System Call for Measures, CMS stated that the selection of measures and measures groups for potential inclusion in the 2012 Physician Quality Reporting System, CMS is primarily interested in measures that have been endorsed by the National Quality Forum (NQF), in accordance with section 1848(k)(2)(C) of the Act. For 2012, CMS also stated that it is particularly interested in individual measures and measures groups that address the following topics:

- Measures that have a high impact on healthcare, such as those that support CMS and Department of Health and Human Services (HHS) priorities for improved quality and efficiency of care for Medicare beneficiaries and those that are included in or facilitate alignment with other Medicare, Medicaid and Children Health Insurance Plan (CHIP) programs
- Measures that address gaps in the quality of care delivered to Medicare beneficiaries
- Measures that address gaps in the Physician Quality Reporting System quality measure set such as those that increase the applicability of the Physician Quality Reporting System measures to services furnished to beneficiaries and expand opportunities for eligible professionals to participate
- Measures impacting chronic conditions (chronic kidney disease, diabetes mellitus, heart failure, hypertension and musculoskeletal conditions)
- Measures involving care coordination
- Measures applicable across care settings (e.g., outpatient, nursing facilities, domiciliary, etc.)
- Outcome measures
- Measures conducive to leveraging capabilities of an EHR
- Measures whose detailed specifications will be completed and ready for implementation in the 2012 Physician Quality Reporting System
- Measures that reflect patient experience
- Broadly applicable measures that could be used to create a core measure set required of all participating eligible professionals
- Measures groups that reflect the services furnished to beneficiaries by a particular specialty

CMS received a total of 91 requests for individual measures and 8 new measures groups in response to the “2012 Physician Quality Reporting System Call for Measures”.

To further inform its deliberation of the 2012 Physician Quality Reporting System program, the design components, and potential measures and measures groups, CMS invites stakeholders to provide input on the following issues:

1. How should individual Physician Quality Reporting System quality measures and measures groups be expanded to be collected through a qualified EHR?
2. Can quality-data codes, instructions, and specifications for new measures and revised measures be completed by measure developers in time to meet CMS' critical timelines?
3. Some Physician Quality Reporting System measures have not been reported by professionals for at least three program years and thus are under consideration for retirement from the Physician Quality Reporting System. Other measures have either a high performance rate; exceeding 90 percent (i.e. are topped out). What are suggestions for considering retirement of these measures?
4. Some measures have a high rate of invalid reporting (i.e., reporting a measure on claims that do not meet denominator inclusion), suggesting that participants may not understand when and how to report a measure. What are suggestions for activities that CMS and stakeholders might undertake to improve education and outreach efforts for participants?
5. High national performance rates for some measures indicate that there is no gap in care and therefore these measures may not be particularly relevant to quality improvement for either professionals or beneficiaries. Some of these measures may not be addressing improvement in outcomes, patient safety or health results. The measure(s) may also be applicable to a relatively small Medicare patient population segment (for example, because of the age range specified in the denominator), which may also skew the performance rate. What are some suggestions for addressing or improving these measures on a timely basis for 2012 program consideration?
6. Which broadly applicable measures should CMS consider including in a core measure set?
7. Which specialties, if any, lack relevant measures?
8. Currently, CMS defines a measures group as a set of 4 or more Physician Quality Reporting System measures that share a common denominator. Should CMS also consider grouping measures by relevance to a particular specialty?

Reporting Options for Individual Eligible Professionals

In order to qualify to earn a Physician Quality Reporting System incentive payment, eligible professionals must meet specified criteria for satisfactorily reporting during the applicable reporting period. Given the broad array of specialties and settings in which eligible professionals practice, CMS has designed the Physician Quality Reporting System program in a manner that, to date, gives eligible professionals flexibility in determining how best to integrate the Physician Quality Reporting System quality measures reporting into their practice workflows.

Tables 1 and 2 describe reporting options available for the 2011 Physician Quality Reporting System based on whether an eligible professional chooses to report individual measures (five reporting options) or measures groups (six reporting options). Although an eligible professional may choose more than one reporting option, to qualify for the 2011 Physician Quality Reporting System incentive payment, the professional must satisfy the reporting criteria under only one of these options.

Table 1 describes the criteria for satisfactory reporting of individual measures based on the reporting mechanism as well as the reporting period that the eligible professional chooses to report the quality measures data. For the 2011 Physician Quality Reporting System, an eligible professional who elects to report individual Physician Quality Reporting System measures can choose to report measures data through claims, through a qualified registry, or through a qualified EHR. In addition, an eligible professional can elect to report measures data for either a 12-month (i.e., January 1, 2011 – December 31, 2011) or for a 6-month (i.e., July 1, 2011 – December 31, 2011) reporting period. The 6-month reporting period, however, is not available for EHR-based reporting of individual measures. In addition, eligible professionals who report on fewer than three individual Physician Quality Reporting System quality measures must report them using one of the claims-based reporting options for individual measures and will be subject to a measure applicability validation (MAV) process prior to determining incentive eligibility. Note: a minimum of three measures must be reported when participating through a qualified registry or a qualified EHR.

Table 1: 2011 Physician Quality Reporting System Reporting Options for Reporting of Individual Measures

Reporting Mechanism(s)	Reporting Criteria	12-Month Reporting Period	6-Month Reporting Period
Claims	Report at least 3 Physician Quality Reporting System measures, (or 1-2 measures if fewer than 3 apply*); <u>and</u> Report each measure for at least 50% of applicable Medicare Part B FFS patients seen during the reporting period	January 1,2011 - December 31, 2011	July 1, 2011 – December 31, 2011
Registry	Report at least 3 Physician Quality Reporting System measures**; <u>and</u> Report each measure for at least 80% of applicable Medicare Part B FFS patients seen during the reporting period	January 1,2011 - December 31, 2011	July 1, 2011 – December 31, 2011

EHR	Report at least 3 Physician Quality Reporting System EHR measures**; <u>and</u> Report each measure for at least 80% of applicable Medicare Part B FFS patients seen during the reporting period	January 1,2011 - December 31, 2011	Not available
-----	--	------------------------------------	---------------

*Eligible professionals who report on fewer than 3 measures may be subject to the Measure-Applicability Validation process.

**Measures with a 0% performance rate will not be counted

Table 2 describes the criteria the applies to satisfactorily reporting measures groups based on the reporting mechanism and reporting period the eligible professional chooses to report. For the 2011 Physician Quality Reporting System, an eligible professional who elects to report measures groups can choose to report them via claims or through a qualified registry. In addition, an eligible professional can choose to report measures groups for either a 12-month (i.e., January 1, 2011 – December 31, 2011) or a 6-month (i.e., July 1, 2011 – December 31, 2011) reporting period.

Table 2: 2011 Physician Quality Reporting System Reporting Options for Reporting of Measures Groups

Reporting Mechanism(s)	Reporting Criteria	12-Month Reporting Period	6-Month Reporting Period
Claims or Registry	Report at least 1 Physician Quality Reporting System measures group*; <u>and</u> Report each measures group for at least 30 <i>unique</i> Medicare FFS patients seen during the reporting period**	January 1,2011 - December 31, 2011	Not available
Claims 12- Month Reporting Period	Report at least 1 Physician Quality Reporting System measures group; Report each measures group for at least 50% of applicable Medicare Part B FFS patients seen during the reporting period; <u>and</u> Report each measures group for at least 15 Medicare Part B FFS patients seen during the reporting period	January 1,2011 - December 31, 2011	Not Applicable

Claims 6- Month Reporting Period	Report at least 1 Physician Quality Reporting System measures group; Report each measures group for at least 50% of applicable Medicare Part B FFS patients seen during the reporting period; <u>and</u> Report each measures group for at least 8 Medicare Part B FFS patients seen during the reporting period	Not Applicable	July 1, 2011 – December 31, 2011
Registry 12- Month Reporting Period	Report at least 1 Physician Quality Reporting System measures group***; Report each measures group for at least 80% of applicable Medicare Part B FFS patients seen during the reporting period; <u>and</u> Report each measures group for at least 15 Medicare Part B FFS patients seen during the reporting period	January 1, 2011 - December 31, 2011	Not Applicable
Registry 6- Month Reporting Period	Report at least 1 Physician Quality Reporting System measures group***; Report each measures group for at least 80% of applicable Medicare Part B FFS patients seen during the reporting period; <u>and</u> Report each measures group for at least 8 Medicare Part B FFS patients seen during the reporting period	Not Applicable	July 1, 2011 – December 31, 2011

*For registry-based reporting, measures groups with a 0% performance rate will not be counted

**Eligible professionals reporting measures groups using the registry-based reporting mechanism will no longer be able to report on non-Medicare FFS patients

***Measures groups with a 0% performance rate will not be counted

Under section 1848(m)(3)(D) of the Act, the Secretary, for years after 2009, has the authority, in consultation with stakeholders and experts, to revise the criteria for satisfactorily submitting data on Physician Quality Reporting System quality measures. Under section 1848(m)(6)(C)(ii) of the Act, the Secretary, for years after 2009, also has the authority to revise the reporting period for the Physician Quality Reporting System if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden.

Given these parameters, CMS invites input on the following discussion questions with respect to the reporting mechanisms, reporting periods, and criteria for satisfactorily reporting for the 2012 Physician Quality Reporting System:

1. What are the advantages/disadvantages of the various reporting mechanisms (e.g., claims, registries, EHRs)?

2. What are the advantages/disadvantages of continuing to make the claims-based reporting mechanism available for Physician Quality Reporting System reporting in light of the availability of alternative reporting mechanisms (qualified registries and EHRs)?
3. How can CMS begin to phase out claims-based reporting without creating unintended barriers to participation?
4. Are the current reporting periods adequate? If not, what other reporting periods would be suggested in lieu of or in addition to the current reporting periods? Why?
5. Eligible professionals reporting on individual measures are currently required to report at least three applicable measures. Is three an appropriate number of measures? If not, what would be an appropriate number of measures? Why? What if CMS required eligible professionals choosing to report individual measures to report on all individual measures for which he or she has patients who are denominator-eligible? What would be the implications?
6. Currently, eligible professionals have the flexibility to select which individual measures or measures group(s) they believe applies to their patient panels. Should CMS identify the relevant professional specialties using claims data for each measure or measures group(s) and then require eligible professionals to report on those identified measures or measures group(s) as being relevant to their particular specialty? How could CMS ensure that an eligible professional's self-designated specialty information (as indicated on their Medicare claims) is accurate?
7. Similarly, what would be the implications if CMS identified a set of broadly applicable measures that all eligible professionals would be required to report, regardless of their specialty?
8. Currently, eligible professionals can choose whether to report on individual measures or measures groups. What are the implications if CMS required eligible professionals to report only on measures groups, unless there were no measures groups applicable to their practice?

Group Practice Reporting Option (GPRO)

As required by the MIPPA, in 2010, CMS introduced a new reporting option for large group practices known as the "GPRO." The GPRO allows a group practice, defined by a unique Tax Identification Number (TIN) with 200 or more individual eligible professionals or National Provider Identifiers (NPIs), to qualify for a Physician Quality Reporting System incentive payment based on the group's TIN's total estimated Medicare Part B PFS allowed charges for the reporting period (CY 2010). For the 2011 Physician Quality Reporting System, CMS retained the option, which is referred to as "GPRO I," and established yet a further GPRO option, "GPRO II." Whereas GPRO I allows a group comprised of 200 or more individual eligible professionals to qualify for a Physician Quality Reporting System incentive payment as a single group, GPRO II allows smaller groups, comprised of a group practice of 2-199 individual eligible professionals, to qualify for a Physician Quality Reporting System incentive payment based on the group's TIN's total estimated Medicare Part B PFS allowed charges for the reporting period (CY 2011).

Group practices who want to be considered for the Physician Quality Reporting System GPRO I or II were required to submit a self-nomination letter to CMS by January 31, 2011 and must be selected by CMS to participate in the 2011 Physician Quality Reporting System GPRO I or II, respectively. If an individual eligible professional bills Medicare under the same TIN as a group practice selected to participate in the Physician Quality Reporting System GPRO I or II, then that individual eligible professional will not be eligible to qualify for a 2011 Physician Quality Reporting System incentive as an individual eligible professional using that TIN/NPI combination. However, if the individual eligible professional, or NPI, also participates in the Physician Quality Reporting System through a different TIN (that is, a different TIN/NPI combination), and that TIN is not a Physician Quality Reporting System GPRO I or II participating TIN, then the eligible professional may report Physician Quality Reporting System measures or measures groups as an individual for that TIN/NPI combination.

CMS invites stakeholder input on the following discussion questions with respect to the GPRO for the 2012 Physician Quality Reporting System:

1. Currently, the Physician Quality Reporting System GPRO I set of quality measures are geared towards primary care. How should CMS expand the Physician Quality Reporting System GPRO I measures to facilitate participation in the GPRO I by specialty practices? For example, should there be specialty-specific measure sets?
2. Currently, a “group practice” is defined as a single TIN of at least 2 individual eligible professionals (as identified by Individual NPIs) who have reassigned their billing rights to the TIN. This definition of a group practice may or may not reflect how a group practice conducts business and/or operates. Some group practices may use multiple TINs or multiple group practices may share a TIN. What other methods can be used to define “group practice” so that the unit of analysis for the Physician Quality Reporting System reporting more accurately reflects how a group practice conducts business and/or operates?
3. Currently an individual eligible professional automatically becomes associated with a TIN, or group practice, when he or she bills Medicare using that TIN during a specified timeframe. What other methods for associating an individual eligible professional with a group practice should CMS consider?
4. Currently, GPRO I is not available to groups with less than 200 eligible professionals. Should CMS consider expanding GPRO I to smaller group practices? If so, what changes, if any, should CMS make to the GPRO I reporting requirements?
5. Currently, GPRO II is not available to groups with more than 199 eligible professionals. Should CMS consider expanding GPRO II to larger group practices? If so, what changes, if any, should CMS make to the GPRO II reporting requirements?

Maintenance of Certification Program Incentive

Starting with the 2011 program year, CMS is implementing a new “Maintenance of Certification Program incentive” under the Physician Quality Reporting System. A Maintenance of Certification Program is a continuous assessment program that advances quality and the lifelong learning and self-

assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism.

Beginning in 2011, a physician can receive an additional 0.5 percent incentive payment when they: 1) satisfactorily submit data, without regard to method, on quality measures under the Physician Quality Reporting System for a 12-month reporting period either as an individual physician or as a member of a selected group practice; 2) more frequently than is required to qualify or maintain board certification status complete a Maintenance of Certification Program; and 3) more frequently than is required to qualify for or maintain board certification status complete a qualified Maintenance of Certification Program practice assessment. CMS has issued additional guidance on the “more frequently” requirement for the Maintenance of Certification Program incentive at <http://www.cms.gov/pqri> > Overview > Downloads.

CMS invites input on the following discussion question with respect to the Maintenance of Certification Program incentive for the 2012 Physician Quality Reporting System:

1. Although Maintenance of Certification Program practice assessments must, by definition, include a patient experience survey, CMS currently does not collect the results of the patient experience surveys. Should CMS consider doing so in the future? If so, how should this information be used? Should CMS set limitations on the types/formats of acceptable patient experience of care surveys? What level of information should CMS collect on the survey?
2. Currently the Maintenance of Certification Program incentive is only available for physicians who satisfactorily report for a 12-month period. Should CMS consider making this additional incentive available to physicians who satisfactorily report for a 6-month reporting option?
3. Are there other ways CMS can apply the “more frequently” requirement to increase physicians' participation in the Maintenance of Certification Program incentive?

Feedback

The Affordable Care Act requires CMS to provide timely feedback to eligible professionals. Each year, the Physician Quality Reporting System incentive payment and the Physician Quality Reporting System feedback report are issued through separate processes specific to a particular program year. The feedback report has evolved since its inception in 2007 when the program provided feedback reports to eligible professional who participated in Physician Quality Reporting at the TIN/NPI level. Reports detail participation in the program includes reporting rate and performance rate information. Physician Quality Reporting System feedback report availability is not based on whether or not an incentive payment was earned. Feedback reports will be available for every TIN under which at least one eligible professional (identified by his or her National Provider Identifier, or NPI) submitting Medicare Part B PFS claims reported at least one valid Physician Quality Reporting System measure a minimum of once during the reporting period. For 2011, the Physician Quality Reporting program will continue to provide feedback reports on or about the time of incentive payment distribution, and in

2012 the program anticipates providing additional, interim feedback reports. For more information on – Physician Quality Reporting System Feedback Reports, see http://www.cms.gov/PQRI/25_AnalysisAndPayment.asp#TopOfPage.

CMS invites input on the following discussion questions with respect to Feedback for the 2012 Physician Quality Reporting System:

1. How often should feedback reports be provided to participating eligible professionals?
2. What types of information would be helpful to include in the annual feedback reports?
3. What types of information would be helpful to include in interim feedback reports?

Informal Review Process

Section 1848(m)(5)(I) of the Act, as amended and added by section 3002(f)(2) of the ACA, requires that the Secretary establish and have in place, no later than January 1, 2011, an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under the Physician Quality Reporting System.

CMS is implementing a new Informal Review Process for the program year 2011 Physician Quality Reporting System which will provide eligible professionals who were not incentive eligible for 2011 the opportunity to request a review of that determination. An eligible professional requesting an informal review must request an informal review within 90 days of the release of his/her feedback report. Eligible professionals may request informal review by notifying the QualityNet Help Desk via email at qnet-support@sdps.org. The request for review must state the concern(s) of the eligible professional and reason(s) for requesting an informal review. The eligible professional may, but is not required to, submit information to assist in the review; however, there is no evidential hearing on the information the eligible professional provides.

CMS will provide a written response via e-mail to the informal review request. Where the eligible professional did satisfactorily report, the applicable incentive payment will be provided. CMS must provide a written response within 60 days of the receipt of the original request. Informal Review decisions are final and there will be no further review.

CMS invites input on the following discussion questions with respect to Informal Appeals Process for the 2012 Physician Quality Reporting System:

1. How can CMS improve the informal appeals process that was implemented for the 2011 Physician Quality Reporting System? Please note that the only issue to be reviewed in the informal review process will be the determination that an eligible professional did not satisfactorily submit data on quality measures under the Physician Quality Reporting System.
2. Is the process for submitting a request for an informal review clear? How can the process be further clarified and simplified for the eligible professional?

Electronic Prescribing (eRx) Incentive Program

In 2008, Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized and defined a new and separate incentive program for eligible professionals (EPs) who are successful electronic prescribers. This incentive program, which began on January 1, 2009, is separate from and is in addition to the Physician Quality Reporting System. Through a combination of incentives and payment adjustments, the eRx Incentive Program encourages the electronic transmission of prescriptions or prescription-related information through electronic media. The eRx transmission takes place directly or through an intermediary (eRx network) between a prescriber, dispenser, pharmacy benefit manager, or health plan. Eligible professionals do not need to participate in the Physician Quality Reporting System to participate in the Electronic Prescribing (eRx) Incentive Program. For each program year, CMS implements the eRx Incentive Program through an annual rulemaking process published in the Federal Register.

For 2009 and 2010, the Secretary is authorized to provide successful electronic prescribers an incentive payment equal to 2.0% of the total estimated allowed charges submitted not later than 2 months after the end of the reporting period. For 2011 and 2012, eligible professionals who are successful electronic prescribers may qualify to earn an incentive payment equal to 1.0% of the total estimated allowed charges submitted not later than 2 months after the end of the reporting period. For 2013, the incentive payment amount is reduced to 0.5%. Beginning in 2012, eligible professionals who are not successful electronic prescribers may be subject to a payment adjustment. Specifically, for 2012 through 2014, if an eligible professional is not a successful electronic prescriber for the reporting period for the year, the PFS amount for covered professional services furnished by such professional during the year shall be less than the PFS amount that would otherwise apply by 1.0% for 2012, 1.5% for 2013, and 2.0% for 2014. For more information on the Electronic Prescribing (eRx) Incentive Program, see <http://www.cms.gov/ERXincentive>.

CMS invites input on the following discussion questions with respect to Electronic Prescribing (eRx) Incentive Program for the 2012 Physician Quality Reporting System:

1. CMS currently requires eligible professionals and group practices participating in the eRx GPRO to report the 2011 eRx measure a specified number of times during the reporting period for purposes of the 2011 eRx incentive payment. Are these reporting thresholds appropriate? What would be the advantages or disadvantages of changing the reporting thresholds?
2. Similarly, for purposes of the 2012 eRx payment adjustment, CMS requires eligible professionals and group practices participating in the eRx GPRO to report the 2011 eRx measure a specified number of times during the reporting period for purposes of the 2012 eRx payment adjustment. Are these reporting thresholds appropriate? What would be the advantages or disadvantages of changing the reporting thresholds?
3. CMS may, on a case by case basis, exempt an eligible professional from application of the payment hardship based on the fact that becoming a successful electronic prescriber would

constitute a significant hardship. For purposes of the 2012 eRx payment adjustment, CMS recognizes 2 hardship exception categories for eligible professionals without sufficient high speed internet access and those with limited available pharmacies. What other circumstances could potentially constitute a significant hardship in that they limit the eligible professional's opportunities to electronically prescribe?

4. What changes, if any, should CMS consider making to the 2011 eRx measure?
5. CMS also has the authority to use Part D data in lieu of the electronic prescribing measure to determine whether an eligible professional or a group practice is a successful electronic prescriber for purposes of the eRx incentive. What would be the advantages or disadvantages of switching to Part D data? What would an appropriate number of electronically prescribed Part D prescriptions for an eligible professional or a group practice to be considered a successful electronic prescriber for purposes of the eRx incentive?
6. If CMS decides to determine that an eligible professional or a group practice is a successful electronic prescriber based on a specified number of electronically prescribed Part D prescriptions for purposes of the eRx incentive, the eligible professional or a group practice must prescribe a sufficient number of Part D prescriptions to be incentive eligible. What would be an appropriate minimum threshold of Part D prescriptions for purposes of being incentive eligible?
7. Similarly, CMS also has the authority to use Part D data to determine whether an eligible professional or a group practice is a successful electronic prescriber for purposes of the eRx payment adjustment. What would be an appropriate number of electronically prescribed Part D prescriptions for an eligible professional or a group practice to be considered a successful electronic prescriber for purposes of the eRx payment adjustment?
8. If CMS decides to determine that an eligible professional or a group practice is a successful electronic prescriber based on a specified number of electronically prescribed Part D prescriptions for purposes of the payment adjustment, the eligible professional or a group practice must prescribe a sufficient number of Part D prescriptions to be subject to the payment adjustment. What would be an appropriate minimum threshold of Part D prescriptions for purposes of being subject to the payment adjustment?
9. How can CMS better align the eRx Incentive Program with the EHR Incentive Program?

Physician Quality Reporting System Beyond 2012

Physician Quality Reporting System incentives, including the additional 0.5% Maintenance of Certification Program incentive, continue through 2014 and provide incentive amounts for 2013 and 2014. Beginning 2015, a payment adjustment will apply under the Physician Quality Reporting System. If eligible professionals do not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year, the fee schedule amount for services furnished by such professionals during the year shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services.

The reduced fee schedule amount for eligible professionals who do not satisfactorily report for 2015 is 98.5 percent and the fee schedule amount for 2016 and subsequent years 98.0 percent

No later than January 1, 2012 CMS is required to develop a plan to move toward integration of the EHR Incentive Program with the Physician Quality Reporting System. Such integration shall consist of the selection of measures where the reporting would demonstrate meaningful use of an EHR for purposes of the EHR Incentive Program, quality of care furnished to an individual, and such other activities as specified by the Secretary.

Beginning in 2012, The Affordable Care Act includes a number of provisions related to physician and other eligible professionals' quality that could impact the Physician Quality Reporting System and/or eRx Incentive Program including the Physician Compare Website, value-based payment modifiers, and the Physician Feedback Program.

CMS announced the release of a Physician Compare Website on December 30, 2010. The Physician Compare Website contains information on eligible professionals enrolled in the Medicare program, including whether the professional satisfactorily reported for the 2009 Physician Quality Reporting System. Currently there is no performance information posted on the Physician Compare Website. By January 1, 2013, CMS is required to implement a plan for posting performance information on the Physician Compare Website for reporting periods beginning no either than January 1, 2012. To the extent practicable, the performance information should include information on Physician Quality Reporting System measures among other types of measures.

The value-based payment modifier is a differential payment under the fee schedule to a physician or groups of physicians based upon the relative quality and cost of care that will be phased in beginning January 1, 2015. CMS may also include information on the quality of care furnished to Medicare beneficiaries by the physician (or a group of physicians) on the confidential reports that are provided under the Physician Feedback Program. CMS invites input on the following discussion questions with respect to Physician Quality Reporting System Beyond 2012:

1. The Affordable Care Act requires CMS to implement a payment adjustment for eligible professionals who do not satisfactorily report beginning in 2015. In order to be able to prospectively make the appropriate adjustments to claims submitted for payment on or after January 1, 2015, CMS needs to make the determination of whether an eligible professional satisfactorily reported well in advance of January 1, 2015. What reporting period(s) should CMS consider using for purposes of the 2015 payment adjustment?
2. What criteria should CMS consider applying for purposes of the payment adjustment?
3. The Affordable Care Act requires CMS to implement a plan, by January 1, 2013, for publicly reporting performance information on the Physician Compare Web site. How should Physician Quality Reporting System performance information reported by participating eligible professionals be used on the Physician Compare Web site?

4. In addition to participating in the Physician Quality Reporting System, eligible professionals may be participating in multiple CMS initiatives, such as but not limited to, the EHR Incentive Program. What steps can CMS take to better align the various CMS initiatives?