Physician Quality Reporting System (PQRS) Changes

**Summary:** Extends through 2014 payments under the Physician Quality Reporting System (PQRS, formerly the Physician Quality Reporting Initiative or PQRI) program, which provide incentives to physicians who report quality data to Medicare. Creates appeals and feedback processes for participating professionals in PQRS. Establishes a participation pathway for physicians completing a qualified Maintenance of Certification program with their specialty board of medicine. Beginning in 2014, physicians who do not submit measures to PQRS will have their Medicare payments reduced.

**Status update:** On July 1, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would update payment policies and rates for physicians and nonphysician practitioners (NPPs) for services paid under the Medicare Physician Fee Schedule (MPFS) in calendar year (CY) 2012, including proposed changes to the Physician Quality Reporting System (PQRS).

**Next steps:**
- June 25, 2010 – CMS issues regulations regarding the PQRS changes.
- August 24, 2010 – Comments due to the CMS regarding the proposed rule.
- Not later than November 1, 2010 – CMS will respond to comments.
- December 15, 2010 – CMS announces a town hall on the PQRS.
- December 20, 2010 – Registration opens for the February 9, 2011 town hall regarding PQRS.
- January 1, 2011 – 1% increase in payments for reporting to the PQRS.
- January 1, 2011 – New payment rates and policies will apply, including changes to the PQRS.
- January 1, 2011 -- Requires an informal appeals process for eligible professionals to request a review of a determination that they did not satisfactorily submit data on the quality measures.
- January 1, 2011 -- Establishes a participation pathway for physicians completing a qualified Maintenance of Certification program with their specialty board of medicine, effective after 2010.
- January 21, 2011 (5 pm) – Written comments due before the February 9, 2011 town hall.
- January 28, 2011 (5 pm) – Registration for February 9, 2011 town hall closes for those who are not presenters.
- February 9, 2011 – CMS town hall on PQRS.
- February 25, 2011 (5 pm) – Additional written comments may be submitted to CMS by this date related to the February 9, 2011 town hall discussion.
- April 19, 2011, CMS issued a report regarding this program.
- May 3, 2011 -- CMS announced a Special Open Door Forum regarding the 2011 PQRS and Electronic Prescribing (eRx) Incentive Programs on Thursday, May 26, 2011.
May 26, 2011 – CMS held a Special Open Door Forum regarding the 2011 PQRS and eRx Incentive programs.

July 1, 2011 – CMS issued proposed rule.

August 30, 2011 – Comments due on proposed rule.

November 1, 2011 – CMS final rule.

January 1, 2012 – Changes for calendar year 2012 go into effect.

By January 1, 2012 -- Requires the Secretary to develop a plan to integrate PQRS and “meaningful use” requirements.

2012-2014 -- 0.5% increase in payments for reporting to the PQRS.

2014 -- 1.5% reduction in payments for not reporting to the PQRS.

2016 and subsequent years -- 2% reduction in payments for not reporting to the PQRS.

Additional information:

• CMS July 1, 2011 fact sheet -- http://www.cms.gov/apps/media/fact_sheets.asp
• CMS May 3 announcement regarding the May 26 Special Open Door Forum – http://www.cms.gov/OpenDoorForums/23_ODF_PNAHP.asp
• CMS April 19 report -- http://www.cms.gov/PQRS/
• CMS overview of PQRS -- http://www.cms.gov/pqri/

Long summary:
Sec. 3002. Improvements to the physician quality reporting system (PQRS) (as modified by sec. 10327).

PQRS incentive. Extends PQRS payment bonuses through 2014. Eligible professionals who successfully report quality data for the quality reporting period designated by the Secretary for the applicable year will receive a 1.0% bonus in 2011 and a 0.5% bonus in years 2012 through 2014.

PQRS penalty. Eligible professionals who do not successfully report quality data during the designated quality reporting period will have their Medicare payments reduced by 1.5% in 2015 and by 2.0% in 2016 and each subsequent year. The payment incentives and reductions are based on the Medicare fee schedule amounts (determined after applicable adjustments) for all covered services furnished by the eligible professional. The penalty applies to the applicable year and is not cumulative. Eligible professionals include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, physical and occupational therapists, qualified speech-language pathologists and qualified audiologists.
**Maintenance of Certification.** Establishes an additional registry option after 2010 for eligible professionals to provide data on quality measures. The provision allows reporting through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the Secretary's criteria for reporting through a registry. Increases the otherwise applicable PQRS incentive payment by 0.5 percentage point for years 2011 to 2014 for eligible professionals: i) for whom required quality data is submitted for a year on their behalf by a qualified American Board of Medical Specialties Maintenance of Certification (MOC) or equivalent program (as determined by the Secretary) that meets the criteria for a registry; and ii) who – more frequently than is required for board certification – participate in an MOC and complete a qualified MOC practice assessment. Other requirements also apply. For years after 2014, authorizes Secretary to incorporate participation in an MOC program and successful completion of a qualified MOC program practice assessment into the composite of measures of quality of care for purpose of the physician fee schedule value-based payment modifier (as outlined in sec. 3007).

**Meaningful use.** By January 1, 2012, requires the Secretary to develop a plan to integrate clinical reporting on quality measures with reporting requirements relating to the meaningful use of electronic health records.

**Feedback and appeals process.** Requires the Secretary to provide timely feedback to eligible professionals concerning whether they are reporting data properly and the likelihood (based on an interim assessment) that they will receive an incentive payment. By January 1, 2011, requires an informal appeals process for eligible professionals to request a review of a determination that they did not satisfactorily submit data on the quality measures.

**Summary of the Regulations:**
CMS proposes to change the definition of "group practice" to groups with 25 or more eligible professionals. This proposed definition of group practice is different from the definition of group practice that was applicable for the 2011 PQRS, which defined a group practice as two or more eligible professionals.

CMS also proposes to consolidate the Group Practice Reporting Option (GPRO) I and II into a single GPRO. However, the agency still recognizes the need to equalize the reporting burden by establishing different reporting criteria for small versus large groups. Therefore, CMS proposes to establish the following two criteria for the satisfactory reporting of PQRS quality measures under the 2012 GPRO, based on the size of the group practice.

- For group practices comprised of 25-99 eligible professionals participating in the GPRO, CMS proposes that the group practice must report on all GPRO measures included in the web interface and Populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 327) for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100% of assigned beneficiaries.

- For group practices comprised of 100 or more eligible professionals, CMS proposes that the group practices must report on all Physician Quality Reporting System GPRO quality measures and populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 616) for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries.
For 2012 and subsequent years, CMS is proposing to eliminate the 6-month reporting period option for claims and registry reporting (that is, registry reporting for individual measures). It will retain the 6 month reporting option for reporting measures groups via registry.

Specific to reporting mechanisms for individuals, CMS proposes to retain the claims-based, registry-based, and EHR-based reporting mechanism for 2012 and beyond. Specific to the EHR-based reporting mechanism, eligible professionals would be required to have a PQRS qualified EHR product, which is different from certified EHR technology for the EHR Incentive Program. CMS is currently exploring ways to further align these two programs’ reporting requirements for future years so that certified EHR Technology may be used to satisfy both the Medicare EHR Incentive Program and the PQRS without any additional testing.

As it pertains to PQRS payments, CMS proposes not to count measures that have a 0 percent performance rate. That is, if the recommended clinical quality action is not performed on at least one patient, CMS will not count the measure.

CMS is also proposing to provide more flexibility to entities sponsoring Maintenance of Certification Programs to define what an eligible professional is required to do to “more frequently” participate in a Maintenance of Certification (MOC) Program for purposes of the PQRS MOC Program Incentive. With regard to feedback reports, CMS proposes to provide interim feedback reports for eligible professionals reporting individual measures and measures groups through the claims-based reporting mechanism for 2012 and beyond. These reports would be a simplified version of annual feedback reports that CMS currently provides for such eligible professionals and would be based on claims for dates of service occurring on or after January 1 and processed by March 31 of the respective program year. Reports would be available in summer of the program year. CMS will also retain the informal review process it implemented in the 2011 PQRS, which used the Quality Net Help Desk.

Finally, CMS announced that the reporting period for purposes of the 2015 PQRS payment adjustment (negative 1.5%) will be the 2013 program year. The adjustment will increase to negative 2% for 2016 and beyond.

**Legislative text:**

**SEC. 3002. IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM.**

(a) EXTENSION. —Section 1848(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A), in the matter preceding clause (i), by striking “2010” and inserting “2014”; and

(B) in subparagraph (B)—

(i) in clause (i), by striking “and” at the end;

(ii) in clause (ii), by striking the period at the end and inserting a semicolon; and

(iii) by adding at the end the following new clauses:

“(iii) for 2011, 1.0 percent; and

“(iv) for 2012, 2013, and 2014, 0.5 percent.”;

(2) in paragraph (3)—

(A) in subparagraph (A), in the matter preceding clause (i), by inserting “(or, for purposes of subsection (a)(8), for the quality reporting period for the year)” after “reporting period”; and

(B) in subparagraph (C)(i), by inserting “, or, for purposes of subsection (a)(8), for a quality reporting period for the year” after “(a)(5), for a reporting period for a year”;

(3) in paragraph (5)(E)(iv), by striking “subsection (a)(5)(A)” and inserting “paragraphs (5)(A) and (8)(A) of subsection (a)”;

(4) in paragraph (6)(C)—

(A) in clause (i)(iii), by striking “, 2009, 2010, and 2011” and inserting “and subsequent years”; and

(B) in clause (iii)—

(i) by inserting “(a)(8)” after “(a)(5)”;

and
(ii) by striking “under subparagraph (D)(iii) of such subsection” and inserting “under subsection (a)(S)(D)(iii) or the quality reporting period under subsection (a)(S)(D)(iii), respectively”.

(b) INCENTIVE PAYMENT ADJUSTMENT FOR QUALITY REPORTING.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w–4(a)) is amended by adding at the end the following new paragraph:

“(8) INCENTIVES FOR QUALITY REPORTING.—

“(A) ADJUSTMENT.—

“(i) IN GENERAL.—With respect to covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).

“(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term ‘applicable percent’ means—

“(I) for 2015, 98.5 percent; and

“(II) for 2016 and each subsequent year, 98 percent.

“(B) APPLICATION.—

“(i) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

“(ii) INCENTIVE PAYMENT VALIDATION RULES.—Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

“(C) DEFINITIONS.—For purposes of this paragraph:

“(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms ‘eligible professional’ and ‘covered professional services’ have the meanings given such terms in subsection (k)(3).

“(ii) PHYSICIAN REPORTING SYSTEM.—The term ‘physician reporting system’ means the system established under subsection (k).

“(iii) QUALITY REPORTING PERIOD.—The term ‘quality reporting period’ means, with respect to a year, a period specified by the Secretary.”

(c) MAINTENANCE OF CERTIFICATION PROGRAMS.—

(1) IN GENERAL.—Section 1848(k)(4) of the Social Security Act (42 U.S.C. 1395w–4(k)(4)) is amended by inserting “or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry” after “Database”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply for years after 2010.

(3) AUTHORITY.—For years after 2014, if the Secretary of Health and Human Services determines it to be appropriate, the Secretary may incorporate participation in a Maintenance of Certification Program and successful completion of a qualified Maintenance of Certification Program practice assessment into the composite of measures of quality of care furnished pursuant to the physician fee schedule payment modifier, as described in section 1848(p)(2) of the Social Security Act (42 U.S.C. 1395w–4(p)(2)).

(d) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended by adding at the end the following new paragraph:

“(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

“(A) The selection of measures, the reporting of which would both demonstrate—

“(i) meaningful use of an electronic health record for purposes of subsection (o); and

“(ii) quality of care furnished to an individual.

“(B) Such other activities as specified by the Secretary.”.

Note: Section 10327(a), p. 826, also added a paragraph (7) to section 1848(m) adding an additional incentive payment relating to physician quality reporting.

(e) FEEDBACK.—Section 1848(m)(5) of the Social Security Act (42 U.S.C. 1395w–4(m)(5)) is amended by adding at the end the following new subparagraph:

“(H) FEEDBACK.—The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.”.

(f) APPEALS.—Such section is further amended—

(1) in subparagraph (E), by striking “There shall” and inserting “Except as provided in subparagraph (I), there shall”; and

(2) by adding at the end the following new subparagraph:

“(I) INFORMAL APPEALS PROCESS.—The Secretary shall, by not later than January 1, 2011, establish and have in place 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 this subsection.”.

Note: Section 10331, p. 830, also provides for public reporting of performance information for eligible professionals who participate in the Physician Quality Reporting Initiative.