

Important changes to 2012 Medicare quality reporting program

Several important changes in the Medicare quality reporting program for physicians take effect in 2012. Physicians who participate between 2011 and 2014 are eligible for incentive payments. Those who do not participate in 2013 and beyond will face a penalty beginning in 2015.

Program background

First established as the Physician Quality Reporting Initiative (PQRI) for the reporting period of July 1 through Dec. 31, 2007, the program was renamed the Physician Quality and Reporting System (PQRS) in 2011. Physicians and non-physician providers who participate in the program transmit data to the Centers for Medicare & Medicaid Services (CMS) regarding quality measures related to care provided to their Medicare patients.

CMS is required to post the names of eligible professionals and group practices who satisfactorily reported under the PQRI, which is currently available on the Medicare Physician Compare [website](#).

The AMA advocated for timely feedback for physicians and an informal appeals process, which the Affordable Care Act (ACA) required by 2011. The ACA also required the development of an additional PQRS reporting option in 2011, allowing physicians to submit data through a maintenance of certification (MoC) program. Physicians who elect this option can receive an additional PQRS incentive payment for three years. Details regarding the MoC reporting option, improved PQRS feedback and an informal appeals process can be found on the [CMS website](#).

Currently, physician quality reporting through PQRS is voluntary; however, the ACA mandates PQRS participation in future years. Recently, CMS finalized regulations requiring that 2015 program penalties be based on 2013 quality reporting. Therefore, those physicians who elect not to participate or do not successfully participate in PQRS during the 2013 program year will receive a 1.5 percent payment penalty in 2015, which increases to 2 percent thereafter.

The AMA is strongly advocating for removal of PQRS penalties, particularly the linking of 2015 program penalties with 2013 performance.

Medicare PQRS incentives and penalties	
2012	0.5% if no MoC; 1% if MoC
2013 (performance year for 2015 penalty)	0.5% if no MoC; 1% if MoC
2014	0.5%
2015	-1.5%
2016	-2%

2012 PQRS overview

Individual reporting: Individual physicians and non-physician providers do not need to sign up or preregister to participate in the 2012 PQRS. Submission of quality data codes for the 2012 PQRS quality measures to CMS through claims, a qualified registry or electronic health record (EHR) will indicate intent to participate in the 2012 program.

Group practice reporting option: Previously there were two classes of group practices that could use the group practice reporting option (GPRO): groups of 2–199 physicians and groups of

200 or more physicians. In 2012, there is a single GPRO for practices comprised of 25 or more eligible professionals.

Group practices will report 29 quality measures on a certain number of consecutive patients in 2012. A group practice with 25–99 professionals is required to report 218 consecutive patients, and a group practice with 100 or more professionals is required to report 411 consecutive patients. CMS will allow practices to “skip” patients for valid reasons, such as not being able to find a patient's medical records or confirm diagnosis.

Unlike PQRS participation for individual physicians, group practices are required to submit a self-nomination letter indicating their interest in participation. More information about the 2012 GPRO option is available on [CMS's website](#).

PQRS measures and measure groups: The 2012 PQRS program will include 210 quality measures available for claims and/or registry reporting, 26 of which are new to the PQRS program. There are an additional 51 measures available for EHR-based reporting, which includes all 44 of the Medicare EHR Incentive Program measures, five PQRS measures that were available in the 2011 EHR reporting option and two new measures CMS developed.

While CMS has eliminated the six-month reporting period for claims and registry reporting for *individual* measures via registry, a six-month reporting period remains for reporting on measures *groups* via a registry.

CMS also added eight measures groups for the 2012 program, bringing the total number of reportable PQRS measures groups to 22. These include: diabetes mellitus, adult kidney disease, preventive care, coronary artery bypass graft, rheumatoid arthritis, perioperative care, back pain, coronary artery disease, heart failure, ischemic vascular disease, hepatitis C, HIV/AIDS, community-acquired pneumonia, asthma, chronic obstructive pulmonary disease, inflammatory bowel disease, sleep apnea, dementia, Parkinson's disease, elevated blood pressure, cardiovascular prevention and cataracts. Because of the limitations of claims-based reporting, some measures groups are only reportable through registries.

Measures contained in the following measures groups will be available for reporting as individual measures: diabetes mellitus, adult kidney disease, preventive care, coronary artery bypass graft, rheumatoid arthritis, perioperative care, coronary artery disease, heart failure, ischemic vascular disease, hepatitis C, HIV/AIDS, community-acquired pneumonia and asthma.

Alignment of the Medicare PQRS and EHR Incentive Program: To align the PQRS with the Medicare EHR Incentive Program, all clinical quality measures available for reporting under the Medicare EHR Incentive Program will be included in the 2012 PQRS. This will allow physicians to report data on quality measures under the EHR-based reporting option.

Reporting threshold: At the AMA's urging, CMS decreased the threshold for successful PQRS claims-based reporting from 80 percent to 50 percent starting in 2011. This reporting threshold will continue for the 2012 program year.

Informal appeals process: In 2012, an eligible professional electing to utilize the informal appeals process must request an informal review within 90 days of the release of his or her feedback report, regardless of when the participant actually accesses his or her feedback report. CMS has extended the time the agency has to respond to the request for an informal review from 60 days in 2011 to 90 days for 2012.

PQRS payment adjustment: Despite strong opposition from the physician community, CMS has designated 2013 as the reporting period for the 2015 PQRS payment penalty. Therefore, if CMS

determines that an eligible professional or group practice has not satisfactorily reported data on quality measures for the Jan. 1–Dec. 31, 2013 reporting period for purposes of the 2015 payment penalty, then the fee schedule amount for services furnished by the participating professional or group practice during 2015 would be 98.5 percent of the fee schedule amount that would otherwise apply to such services.

Refer to [CMS's website](#) for additional information on PQRS, including measures, measures groups, reporting options and periods.

AMA PQRS participation tools

The AMA is developing participation tools for both the individual quality measures and measures groups eligible for claims-based reporting in the 2012 PQRS program. These tools will soon be available on the [AMA website](#). Please email questions or comments about the tools to cpe@ama-assn.org.