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CY15 Medicare Physician Fee Schedule Final Rule Fact Sheet

Overview

The Centers for Medicare & Medicaid Services (CMS) released a final rule with comment period in November that revises payment policies under the Medicare Physician Fee Schedule (PFS) and makes other policy changes related to Medicare Part B payment. Unless otherwise noted, these proposed changes are applicable to services furnished in Calendar Year 2015 (CY15). The rule also includes finalized proposals associated with PFS payments, including the Physician Quality Reporting System (PQRS), the Medicare Shared Savings Program (MSSP), updates to the Physician Compare website, and the Electronic Health Record (EHR) Incentive Program. The rule also discusses updates to the physician value-based payment modifier (value modifier), created by the Affordable Care Act (ACA), which will affect payments to certain physician groups based on the quality and cost of care they furnish to beneficiaries enrolled in the Medicare fee-for-service program, and the Physician Feedback Program. Any changes in payment rate discussed in this summary do not incorporate the impact of sequestration resulting from the Budget Control Act of 2011.

Allowed Expenditures for Physicians' Services and the Sustainable Growth Rate (SGR)

Federal Register, pages 67734-67742, 67986-67987

Final Update Summary: Section 601 of the American Taxpayer Relief Act (ATRA) of 2012 provided a 0.0 percent update for Calendar Year 2013, effective Jan. 1, 2013, through Dec. 31, 2013, and specified that the conversion factors (CFs) for subsequent time periods must be computed as if the increases in previous years had not been applied. Section 1101 of the Pathway for SGR Reform Act of 2013 provided a 0.5 percent update to the CF, effective Jan. 1, 2014, through March 31, 2014, and specified that the CFs for subsequent time periods must be computed as if the increases in previous years had not been applied. Section 101 of the Protecting Access to Medicare Act (PAMA) of 2014 extended this 0.5 percent update through Dec. 31, 2014. Section 101 of the PAMA also provides a 0.0 percent update for services furnished on or after Jan. 1, 2015, through March 31, 2015, and specified that the CFs for subsequent time periods must be computed as if the increases in previous years had not been applied. Therefore, under current law, the CF that would be in effect in Calendar Year 2014 (CY14) had the prior increases specified above not applied is **\$27.2006**.

Increases or decreases in Relative Value Units (RVUs) may not cause the amount of expenditures for the year to differ more than \$20 million from what it would have been in the absence of these changes. If this threshold is exceeded, CMS must make adjustments to preserve budget neutrality. CMS estimates that CY15 RVU changes would result in an increase in Medicare physician expenditures of more than \$20 million, and, therefore, is decreasing the CF by **0.06** percent to offset this estimated increase in Medicare physician expenditures due to the CY15 RVU changes. For Jan. 1, 2015, through March 31, 2015, the PFS update will be 0.0 percent consistent with section 101 of PAMA. After applying the budget neutrality adjustment, the CF for Jan. 1, 2015, through March 31, 2015, will be **\$35.8013**. After March 31, 2015, the standard calculation of the PFS CF under the SGR formula would apply. Therefore, from April 1, 2015, through Dec. 31, 2015, the conversion factor would be **\$28.2239**. The final rule with comment period announces a reduction to payment rates for physicians' services of **21.2** percent during this time period in CY15 under the SGR formula.

CMS illustrates the calculation of the CY15 PFS CF in Table 45 of the final rule.

Anesthesia CF

The anesthesia CF in effect in CY14 is \$22.6765. Section 101 of PAMA provides for a 0.0 percent update from Jan. 1, 2015, through March 31, 2015. After applying the **0.9994** budget neutrality factor, the anesthesia CF in effect from Jan. 1, 2015, through March 31, 2015, will be **\$22.5550**. CMS included adjustments to the anesthesia CF that are analogous to the physician fee schedule CF with other adjustments that are specific to anesthesia. Accordingly, under current law, the anesthesia CF in effect in CY15 for the time period from April 1, 2015, through Dec. 31, 2015, is **\$17.7913**. CMS illustrates the calculation of the CY15 anesthesia CF in Table 46 of the final rule.

Table 93 shows the payment impact on PFS services. To the extent that there are year-to-year changes in the volume and mix of services provided by physicians, the actual impact on total Medicare revenues will be different from those shown in this table.

Resource-Based Practice Expense (PE) RVUs

Federal Register, pages 67551, 67553, 67560

Final Update Summary: CMS discusses several CY15 revisions related to direct PE inputs for specific services. The final direct PE inputs are included in the final rule CY15 direct PE input database, which is available on the CMS website under downloads for the CY15 PFS final rule with comment period at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html>

Malpractice RVUs

Federal Register, pages 67591-67596

CMS proposed minor refinements for updating the CY15 Malpractice (MP). As discussed in the CY15 proposed rule, CMS did not include an adjustment under the anesthesia fee schedule to reflect updated MP premium information and stated that it intended to propose anesthesia adjustment for MP in the Calendar Year 2016 (CY16) PFS proposed rule. Information on the CY15 update may be found in the CMS contractor's report, "Final Report on the CY15 Update of Malpractice RVUs," which is available on the CMS website. It is also located under the supporting documents section of the CY15 PFS final rule with comment period located at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/PhysicianFeeSched/>

Geographic Practice Cost Indices (GPCIs)

Federal Register, pages 67596-67598

Final Update Summary: For CY15, CMS is not making any revisions related to the data or the methodologies used to calculate the GPCI, except in regard to the Virgin Islands locality. However, since the 1.0 work GPCI floor provided in section 1848(e)(1)(E) of the Act is set to expire on March 31, 2015, CMS has included two sets of GPCIs and GAFs for CY15. One set is for Jan. 1, 2015, through March 31, 2015, and another set is for April 1, 2015, through Dec. 31, 2015. The first set of GPCIs and GAFs reflect the statutory expiration of the 1.0 work GPCI floor.

Section 102 of the PAMA extended the 1.0 work GPCI floor through March 31, 2015. Therefore, the CY15 work GPCIs and summarized geographic adjustment factors (GAFs) have been revised

to reflect the 1.0 work floor. Additionally, as required by sections 1848(e)(1)(G) and 1848(e)(1)(I) of the Act, the 1.5 work GPCI floor for Alaska and the 1.0 PE GPCI floor for frontier states are permanent, and, therefore, applicable in CY15. Addenda D and E of the final rule contain CY15 GPICs and summarized GAFs.

Telehealth Services

Federal Register, pages 67598-67602

Final Update Summary: CMS received several requests in Calendar Year 2013 (CY13) to add various services as Medicare telehealth services effective for CY15. CMS will add the following codes to this list on a category 1 basis:

- Psychotherapy services - CPT codes 90845, 90846, and 90847
- Prolonged service office - CPT codes 99354 and 99355
- Annual wellness visit - HCPCS codes G0438 and G0439

Because the list of Medicare telehealth services has grown quite lengthy, and given the many other mechanisms by which CMS can make the public aware of the list of Medicare telehealth services for each year, CMS will change its regulation at § 410.78(b) by deleting the description of the individual services for which Medicare payment can be made when furnished via telehealth. CMS will continue its current policy to address requests to add services to the list of Medicare telehealth services through the PFS rulemaking process so that the public has the opportunity to comment on additions to the list. CMS is also finalizing its proposal to revise § 410.78(f) to indicate that a list of Medicare telehealth codes and descriptors is available on its website.

Background: Generally, for Medicare payments to be made for telehealth services under the PFS, several conditions must be met. Specifically, the service must be on the Medicare list of telehealth services and meet the following other requirements for coverage.

- The service must be furnished via an interactive telecommunications system.
- The practitioner furnishing the service must meet the telehealth requirements, as well as the usual Medicare requirements.
- The service must be furnished to an eligible telehealth individual.
- The individual receiving the services must be in an eligible originating site.

When all of these conditions are met, Medicare pays an originating site fee to the originating site and provides separate payment to the distant site practitioner for furnishing the service. The originating site fee for 2015 is **\$24.83**. Medicare telehealth services can be furnished only to an eligible telehealth beneficiary in a qualifying originating site. An *originating site* is defined as one of the specified sites where an eligible telehealth individual is located at the time the service is being furnished via a telecommunications system. As specified in regulations at § 410.78(b), CMS generally requires that a telehealth service be furnished via an interactive telecommunications system. Medicare telehealth services may be furnished to an eligible telehealth individual notwithstanding the fact that the practitioner furnishing the telehealth service is not at the same location as the beneficiary. An eligible telehealth individual is an individual enrolled under Part B who receives a telehealth service furnished at an originating site. Effective Jan. 1, 2014, CMS changed its policy so that geographic eligibility for an

originating site would be established and maintained on an annual basis, consistent with other telehealth payment policies. Geographic eligibility for Medicare telehealth originating sites for each calendar year is now based upon the status of the area as of Dec. 31 of the prior calendar year.

Removal of Employment Requirements for Services Furnished “Incident to” Rural Health Clinics and Federally Qualified Health Center Visits

Federal Register, page 67751

Final Update Summary: To provide rural health clinics (RHCs) and federally qualified health centers (FQHCs) with as much flexibility as possible to meet their staffing needs, CMS will revise, remove, and delete many of the requirements pertaining to “incident to” services provided by RHC and FQHC visits. Specifically, CMS will remove the requirement that services furnished incident to an RHC or FQHC visit must be furnished by an employee of the RHC or FQHC to allow nurses, medical assistants, and other auxiliary personnel to furnish “incident to” services under contract in RHCs and FQHCs. CMS believes that removing the requirements will provide RHCs and FQHCs with additional flexibility without adversely impacting the quality or continuity of care.

Chronic Care Management (CCM)

Federal Register, pages 67715-67730

Final Update Summary

CCM Services

Chronic care management is a unique PFS service designed to pay separately for non face-to-face care coordination services furnished to Medicare beneficiaries with two or more chronic conditions. In the CY14 PFS final rule, CMS indicated that, to recognize the additional resources required to provide CCM services to patients with multiple chronic conditions, it was creating code **GXXXI** to use for reporting this service. However, after learning about the administrative difficulties that the 30-day period would create, CMS believes that the calendar month creates a reasonable period. Accordingly, it will adopt CPT *code 99490* (Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional) for Medicare CCM services, effective Jan. 1, 2015, instead of the G code.

CCM and Transitional Care Management (TCM) Services Furnished Incident to a Physician’s Service Under General Physician Supervision

In the CY14 PFS final rule, CMS discussed how the policies relating to services furnished incident to a practitioner’s professional services apply to CCM services. Specifically, CMS addressed the policy for counting clinical staff time for services furnished incident to the billing practitioner’s services toward the minimum amount of service time required to bill for CCM services. CMS established an exception to the usual rules that apply to services furnished incident to the services of a billing practitioner. The exception created is one to the generally applicable requirement that “incident to” services must be furnished under direct supervision. CMS will revise the policy that it adopted in the CY14 PFS final rule to amend its regulations to codify the requirements for CCM services furnished incident to a practitioner’s services. Specifically, CMS will remove the requirement that, in order to count the time spent by clinical staff providing aspects of CCM services toward the CCM time requirement, the clinical staff person must be a direct employee of the practitioner or the practitioner’s practice. CMS is

finalizing its proposal to revise its regulation at § 410.26, which sets out the applicable requirements for “incident to” services, to permit the CCM and non-face-to-face portion of the TCM services provided by clinical staff incident to the services of a practitioner to be furnished under the general supervision of a physician or other practitioner.

Scope of Services and Standards for CCM Services

CMS finalized its proposal for the CCM scope of service element for EHR technology as proposed with modification. CMS will include as an element of the separately billable CCM service, the use of, at a minimum, technology certified to the edition(s) of certification criteria that is acceptable for the EHR Incentive Programs as of Dec. 31 of the calendar year prior to the PFS payment year (CCM certified technology), to meet the final core EHR capabilities (structured recording of demographics, problems, medications, medication allergies and the creation of a structured clinical summary record) and to fulfill all activities within the final scope of service elements that reference a health or medical record. This will ensure that requirements for CCM billing under the PFS are consistent throughout each PFS payment year and are automatically updated annually according to the certification criteria required for the EHR Incentive Programs.

For CCM payment in CY15, this policy will allow practitioners to use EHR technology certified to either the 2011 or 2014 edition(s) of certification criteria to meet the final core capabilities for CCM and to fulfill the CCM scope of service requirements whenever the requirements reference a health or medical record. The final scope of service elements that refer to a health or medical record and that must be fulfilled using the CCM-certified technology are summarized in Table 33 of the final rule.

CMS is also finalizing the electronic care plan and 24/7 access elements as proposed, clarifying that, to satisfy the care plan scope of service element, practitioners must electronically capture care plan information and make this information available to all care team members furnishing CCM services that are billed by a given practice (counting towards the minimum monthly service time), even when furnishing CCM outside of normal business hours. In addition, practitioners must electronically share care plan information as appropriate with other providers and practitioners who are furnishing care to the patient. Although CMS is not requiring that practitioners use a specific electronic technology at this time (other than not allowing facsimile), it may revisit this requirement as standards-based exchange of care plan information becomes more widely available in the future.

Payment of CCM Services in CMS Models and Demonstrations

CMS models and demonstrations, such as the Multi-payer Advanced Primary Care Practice Demonstration and the Comprehensive Primary Care Initiative, both include payments for care management services that closely overlap with the scope of service for the new CCM services code. In these two initiatives, primary care practices are receiving per beneficiary per month (PBPM) payments for care management services furnished to Medicare fee-for-service beneficiaries attributed to their practices. CMS is finalizing its proposed policy that it will not pay practitioners participating in one of these two initiatives for CCM services furnished to any beneficiary attributed by the initiative to the practice. These practitioners may bill Medicare for CCM services furnished to eligible beneficiaries who are not attributed by the initiative to the practice. As the Innovation Center implements new models or demonstrations that include payments for care management services, or as changes take place that affect existing models or demonstrations, it will address potential overlaps with the CCM service and seek to implement

appropriate payment policies.

Physician Compare Website

Federal Register, pages 67768-67776

Final Update Summary

Public Reporting of Performance and Other Data

CMS finalized in the CY14 PFS rule all measures collected through the PQRS Group Practice Reporting Option (GPRO) web interface for groups of two or more eligible professionals (EPs) participating in 2014 and for Accountable Care Organizations (ACOs) participating in the MSSP would be available for public reporting in CY15. These data include performance rates for measures reported that meet the minimum sample size of 20 patients and prove to be statistically valid. For CY15, CMS also finalized a decision to publicly report, via Physician Compare, performance on certain measures that group practices report via registries and EHRs in 2014 for the PQRS GPRO.

CMS also finalized publicly reporting patient experience survey-based measures from the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) measures for groups of 100 or more EPs who participate in PQRS GPRO and for MSSP ACOs reporting through the web interface or other CMS-approved method. For 2014, CMS finalized reporting data for the 12 summary survey measures also for groups of 25 to 99. CMS finalized publicly reporting 20 individual measures collected through a registry, EHR, or claims. The measures are reported by groups via the GPRO web interface. *Appendix 1* of this document (Table 48 of the final rule) contains a summary of the final policies for publicly reporting data on Physician Compare.

Group practices will be given a 30-day preview period to view their measures as they will appear on Physician Compare prior to the measures being published. CMS will publicly report all 2015 individual EP PQRS measures collected through a registry, EHR, or claims, except for those measures that are new to PQRS and thus in their first year.

Public Data Disclosure on Physician Compare in 2015 and 2016

CMS will publicly report all 2015 PQRS measures by the various reporting options for group practices of two or more EPs participating in PQRS GPRO and all 2015 measures reported by ACOs. For individual EPs, CMS will publicly report all 2015 PQRS measures collected through a registry, EHR, or claims, except for those measures that are new to PQRS.

CMS finalized its proposal to report the 12 summary CAHPS measures outlined in the final rule on Physician Compare for group practices and ACOs, as appropriate.

CMS will make available on Physician Compare, 2015 Qualified Clinical Data Registry (QCDR) measure data collected at the individual level or aggregated to a higher level of the QCDR's choosing— such as the group practice level, if technically feasible. CMS will review all data prior to public reporting to ensure that the measures included meet the same standards as the PQRS measures being publicly reported. No newly available QCDR measures available for reporting will be reported for at least one year. The 2015 QCDR data will be published on the Physician Compare website in 2016.

The following table (Table 49 of the final rule) summarizes the Physician Compare proposals CMS is finalizing with regard to 2015 data.

TABLE 49—SUMMARY OF FINALIZED DATA FOR PUBLIC REPORTING

Data collection year	Publication year	Data type	Reporting mechanism	Finalized proposals regarding quality measures and data for public reporting
2015	2016	PQRS, PQRS GPRO, EHR, and Million Hearts.	Web Interface, EHR, Registry, Claims.	Include an indicator for satisfactory reporters under PQRS, participants in the EHR Incentive Program, and EPs who satisfactorily report the individual PQRS Cardiovascular Prevention measures in support of Million Hearts.
2015	2016	PQRS GPRO & ACO GPRO.	Web Interface, EHR, Registry, and Administrative Claims.	All 2015 PQRS GPRO measures reported via the Web Interface, EHR, and Registry that are available for public reporting for group practices of 2 or more EPs and all measures reported by ACOs with a minimum sample size of 20 patients.

Data collection year	Publication year	Data type	Reporting mechanism	Finalized proposals regarding quality measures and data for public reporting
2015	2016	CAHPS for PQRS& CAHPS for ACOs.	CMS-Specified Certified CAHPS Vendor.	2015 CAHPS for PQRS for groups of 2 or more EPs and CAHPS for ACOs for those who meet the specified sample size requirements and collect data via a CMS-specified certified CAHPS vendor.
2015	2016	PQRS	Registry, EHR, or Claims.	All 2015 PQRS measures for individual EPs collected through a Registry, EHR, or claims.
2015	2016	QCDR data	QCDR	All individual-EP level 2015 QCDR data.

Physician Quality Reporting System (PQRS)

Federal Register, pages 67777-67905

Final Update Summary: This section contains the final requirements for the PQRS. The requirements in this rule primarily focus on the 2017 PQRS payment adjustment, which will be based on an EP’s or a group practice’s reporting of quality measures data during the 12-month calendar year reporting period occurring in 2015 (that is, Jan. 1 through Dec. 31, 2015). CMS notes that it continues to focus on aligning its requirements with other quality reporting programs, such as the Medicare EHR Incentive Program for Eligible Professionals, the Value Modifier (VM), and the MSSP, where and to the extent appropriate and feasible.

Changes to the Requirements for the Qualified Registry

CMS is not finalizing its proposal to require that qualified registries be able to report on all cross-cutting measures specified in Table 52 of the final rule for which the registry’s participating EPs are able to report. CMS notes, however, that EPs and group practices using the registry-based reporting mechanism that see at least one Medicare patient in a face-to-face encounter must still report on one cross-cutting measure to meet the criteria for satisfactory reporting for the 2017 PQRS payment adjustment. CMS will also extend the deadline for qualified registries to submit quality measures data, including, but not limited to, calculations and results, to March 31 following the end of the applicable reporting period (for example, March 31, 2016, for reporting periods ending in 2015).

Requirements for the Direct EHR and EHR Data Submission Vendor Products That are Certified EHR Technology (CEHRT)

Direct EHRs and EHR data submission vendors must comply with CMS Implementation Guides for both the QRDA–I and QRDA–III data file formats. The Implementation Guides for 2014 are available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Guide_QRDA_2014eCQM.pdf.

Updated guides for 2015, when available, will be posted on the CMS EHR Incentive Program website at <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/>. These guidelines are not available on the CMS website yet, but we will update this document to reflect this when they become available.

CMS will continue applying these requirements to direct EHR products and EHR data submission vendor products for 2015 and beyond. CMS will have the EP or group practice provide the CMS EHR certification number of the product used by the EP or group practice for direct EHRs and EHR data submission vendors.

Final Changes to the Requirements for the QCDR

In the CY14 PFS final rule with comment period, CMS established certain requirements for entities to become QCDRs for the purpose of having their participating EPs meet the criteria for the PQRS incentives and payment adjustments. Specifically, in accordance with the final criterion that required EPs to report on at least one outcome measure, CMS required that an entity possess at least one outcome measure for which its participating EPs may report.

Consistent with its final criterion for the satisfactory participation in a QCDR for the 2017 PQRS payment adjustment, CMS is finalizing the following requirement for QCDRs: a QCDR must possess at least two outcome measures. If the QCDR does not possess two outcome measures, then, in lieu of two outcome measures, the QCDR must possess at least one outcome measure and one of the following other types of measures—resource use, patient experience of care, efficiency/appropriate use, or safety.

Additionally, CMS finalized its proposal that, beginning with the 2017 PQRS payment adjustment, a QCDR may submit quality measures data for a maximum of 30 non-PQRS measures. CMS notes that this limit does not apply to measures contained in the PQRS measure set, as QCDRs can report on as many measures in the PQRS measure set as they wish. CMS also notes that QCDRs are not required to report on 30 non-PQRS measures.

CMS' experience during the 2014 self-nomination process shed light on clarifications needed on what is considered a non-PQRS measure. To clarify the definition of non-PQRS measures, CMS finalized the following parameters for a measure to be considered a non-PQRS measure:

- A measure that is not contained in the PQRS measure set for the applicable reporting period
- A measure that may be in the PQRS measure set, but has substantive differences in the manner that it is reported by the QCDR.

Public Reporting of QCDR Quality Measures Data

CMS requires an entity make available to the public the quality measures data for which its EPs report. However, it provides an exception to this requirement for new PQRS and non-PQRS measures that are in their first year of reporting by a QCDR under the PQRS. After the initial year of reporting a new measure, performance data for the measure will be made available to the public. CMS is extending the deadline by which a QCDR must publicly report quality measures data outside of Physician Compare to the deadline by which Physician Compare posts QCDR quality measures data as discussed in section II.J of the final rule. That is, as indicated in Table 49 in section III.J.3 of the final rule, QCDRs wishing to publicly report quality measures data outside of Physician Compare must do so in 2016 for reporting periods occurring in 2015.

Changes to the GPRO Web Interface

CMS will modify the deadline that a group practice must register to participate in the GPRO to June 30 of the year in which the reporting period occurs (e.g. June 30, 2015, for reporting periods occurring in 2015). This deadline applies to all group practices using any reporting mechanism available for reporting in the GPRO (that is, GPRO web interface, registry, EHR, and/or CMS-certified survey vendor).

Criteria for Satisfactory Reporting for Individual Eligible Professionals for the 2017 PQRS Payment Adjustment

To be consistent with the satisfactory reporting criterion finalized for the 2014 PQRS incentive, CMS modifies § 414.90(j) and the criterion for individual EPs reporting via claims and registry. These finalized criteria can be found in **Appendix 2** (Table 50 of the final rule).

Cross-Cutting Measure Set for 2015 and Beyond

Appendix 3 of this rule (Table 51 of the final rule) contains the final criteria for satisfactory reporting of data on PQRS quality measures via the GPRO for the PQRS payment adjustment for CY17. CMS will add diabetes-related measure *NQF 0059 Diabetes: Hemoglobin A1c Poor Control* to the list of cross-cutting measures, based on comments that were submitted. CMS has changed some of the reporting mechanisms available for certain crosscutting measures in Table 52 of the final rule from the reporting options it proposed would be available in the CY15 PFS proposed rule. CMS has modified its proposal to only require the reporting of 1 cross-cutting measure from the final list of cross-cutting measures of 19 to reduce provider burden. CMS will only require EPs who see at least one Medicare patient in a face-to-face encounter to report on one cross-cutting measure.

New PQRS Measures Available for Reporting for 2015 and Beyond

CMS finalized additional measures in the PQRS measure set for CY15 and beyond. In Table 53 of the final rule, CMS provides its response to the comments received on these measures as well as its final decisions on these proposed measures. CMS has also indicated the PQRS reporting mechanism or mechanisms through which each measure could be submitted.

2014 PQRS Data Submission Timeframes

CMS has made available the following PQRS data submission timeframes for 2014:

Reporting Method	Submission Period	Submission Deadline Time (All Times are Eastern)
EHR Direct or Data Submission Vendor that is certified EHR technology (CEHRT)	1/1/15 - 2/28/15	8:00 p.m.
Qualified clinical data registries (QCDRs) (using QRDA III format) reporting for PQRS and the clinical quality measure (CQM) component of meaningful use for the Medicare Electronic Health Record (EHR) Incentive Program	1/1/15 - 2/28/15	8:00 p.m.
Group practice reporting option (GPRO) Web Interface	1/26/15 - 3/20/15	8:00 p.m.
Qualified registries	1/1/15 - 3/31/15	8:00 p.m.
QCDRs (using XML format) reporting for PQRS only	1/1/15 - 3/31/15	8:00 p.m.
Maintenance of Certification Organizations (MOCs)	1/1/15 - 3/31/15	8:00 p.m.

Medicare Shared Savings Program

Federal Register, pages 67907-67931

Final Update Summary

Changes to the Quality Measures Used in Establishing Quality Performance Standards that ACOs Must Meet to be Eligible for Shared Savings

CMS continues to review the quality measures used for the MSSP to ensure they are aligned with current clinical practice and the PQRS GPRO web interface. Based on the reviews, CMS identified a number of proposed measure additions, deletions, and other revisions that it believes would be appropriate. Although the number of measures ACOs must report remains at 33, CMS reduced the number of measures reported through the web interface by 5. Additionally, CMS reduced the number of patients ACOs are required to report on for each measure.

The new measures will be pay-for-reporting for the first two performance years for all ACOs. After this initial period, the measures will be phased in to pay-for-performance over the course of an ACO's first agreement period, with the exception of *Depression Remission at 12 Months*, which will stay at pay-for-reporting for all three performance years. CMS provides a list of the final measures and further details of phase-in to pay-for-performance during the agreement period in Table 81.

Quality Performance Benchmarks

CMS will use flat percentages when the national fee-for-service (FFS) data results in the 90th percentile for a measure are greater than or equal to 95 percent. Although this policy is similar to the current policy for setting benchmarks based on flat percentages when the 60th percentile is equal to or greater than 80.00 percent, CMS clarifies that this methodology would apply to all measures, including measures whose performance rates are calculated as ratios, for example, measures such as the ACO Ambulatory Sensitive Conditions Admissions and the All Condition

Readmission measure.

CMS will set benchmarks for two years to provide ACOs with stable targets for quality improvement. In addition, it will use up to three years of FFS data to set benchmarks, if available. The use of multiple years of FFS data to set benchmarks will apply to all newly established benchmarks, but will not affect existing benchmarks, which apply to the 2014 and 2015 performance years.

Rewarding Quality Improvement

CMS finalized providing an additional quality improvement reward for MSSP Program ACOs who demonstrate quality improvement on measures in a domain. Specifically, for each quality measure domain, CMS will award an ACO up to four additional bonus points for quality performance improvement on the quality measures within the domain.

These bonus points would be added to the total points that the ACO achieves within each of the four domains. The total possible points that can be achieved in a domain, including up to four bonus points, could not exceed the maximum total points achievable within the domain. Table 82, which shows the number of points available per domain under the revised quality performance standard, reflects the current quality measure scoring methodology, which will continue. Consistent with its current quality scoring methodology, the total points earned for measures in each domain, including any quality improvement bonus points up to the total possible points for the domain, will be summed and divided by the total points available for that domain to produce an overall domain score of the percentage of points earned versus points available.

The percentage score for each domain will be averaged together to generate a final overall quality performance score and sharing rate for each ACO that will be used to determine the percentage of savings it shares or, if applicable, the percentage of losses it owes, consistent with the methodology established under § 425.502(e). The calculation of the quality improvement measure for each domain would generally be based on the formula used for the Medicare Advantage (MA) five-star rating program, as follows:

Improvement Change Score = score for a measure in performance year minus score in previous performance year.

For each qualifying measure, CMS will determine whether there was a significant improvement or decline between the two performance years by applying a “t-test,” which is a common standard statistical test, at a 95 percent level of confidence. The bonus points, up to a maximum of four points, will be awarded in direct proportion to the ACO’s net improvement for the domain to the total number of individual measures in the domain. For example, there are eight individual measures for the patient/ caregiver experience of care domain. If an ACO achieves a significant quality increase in all eight measures, the ACO would be awarded the maximum of four bonus points for this domain. However, if the ACO achieved a significant quality increase in only one of the eight measures in this domain and no significant quality decline on any of the measures, the ACO would be awarded bonus points for quality improvement in the domain that is $1/8 \text{ times } 4 = 0.50$. The total points that the ACO could achieve in this domain could still not exceed the current maximum of 16 points shown in Table 82. CMS will add a new paragraph (4) to § 425.502(e) to incorporate the new bonus points scoring methodology, but is revising the proposed language in order to reflect its decision to award up to four bonus points per domain.

Value-Based Payment Modifier (VBM) and Physician Feedback Program

Federal Register, pages 67931-67966

Final Update: In the rule, CMS finalizes several proposed VBM policies that it included in the CY15 PFS proposed rule.

See *Appendix 4* for an implementation table that displays information about the value modifier (VM).

Solo Practitioners in 2017

- CMS is finalizing the definition of a “solo practitioner” to mean: “a single Tax identification number (TIN) with one eligible professional who is identified by an individual National Provider Identifier billing under the TIN.”
- CMS also finalized, beginning in CY17, a group or solo practitioner will receive a cost composite score that is classified as “average” under the quality-tiering methodology if the group or solo practitioner does not have at least one cost measure with at least 20 cases and codifying the policy as proposed.

Approach to Setting the VM Adjustment Based on PQRS Participation

In CY15, CMS will use a two-category approach to phase in the VM in 2015 to groups of physicians with 100 or more EPs. Groups in Category 1 may elect the quality-tiering methodology to calculate the VM to be applied to their PFS payments in CY15. Specifically, CMS categorizes groups of physicians eligible for the VM into two categories:

Category 1 - includes groups of physicians that have:

- a. self-nominated/registered for the PQRS as a group and reported at least one measure (also includes those groups that have self-nominated/registered and have met the satisfactory reporting criteria for the PQRS incentive payment)
 - b. elected the PQRS Administrative Claims option as a group.
- For those groups of physicians within Category 1 that have elected to have their VM based on quality-tiering and have either met the satisfactory reporting criteria for the PQRS incentive or chosen the PQRS Administrative Claims option:
 - CMS will use the performance rates on the quality measures reported through these reporting mechanisms (e.g., GPRO web-interface, CMS-qualified registry, or PQRS Administrative Claims option) and the three outcome measures to calculate their VM.
 - Quality-tiering could result in an upward, downward, or no payment adjustment.
 - For those groups of physicians within Category 1 that have elected to have their VM based on quality-tiering, but did not meet the satisfactory reporting criteria for the PQRS incentive, CMS will use the group’s performance on the PQRS Administrative Claims measures for quality-tiering. Although the group self-nominated/registered and reported at least one measure, CMS would not have sufficient quality information to construct a quality composite under the quality-tiering approach.

- If the groups of physicians in Category 1 (both (a) and (b)) do not elect quality-tiering, then the VM will be 0.0 percent, meaning no payment adjustment will be applied to physicians in these groups for CY15.

Category 2 - includes those groups of physicians with 100 or more EPs that do not fall within either of the two subcategories (a) and (b) of Category 1 described above. The VM for these groups of physicians will be -1.0 percent in CY15.

Quality-tiering Model

The quality-tiering model compares the quality of care composite with the cost composite to determine the VM. Under the quality-tiering approach, each group’s quality and cost composites are classified into high, average, and low categories depending upon whether the composites are at least one standard deviation above or below the mean. CMS compares the group’s quality of care composite classification with the cost composite classification to determine the VM adjustment for the CY15 payment adjustment period according to the amounts in the table below (Table 97 of the final rule).

TABLE 97—2015 VALUE-BASED PAYMENT MODIFIER AMOUNTS UNDER QUALITY-TIERING

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

*Groups of physicians eligible for an additional +1.0x if (1) reporting Physician Quality Reporting System quality measures through the GPRO web-interface or CMS-qualified registry, and (2) average beneficiary risk score is in the top 25 percent of all beneficiary risk scores.

Quality-tiering is mandatory for groups and solo practitioners within Category 1 for the CY17 VM. Solo practitioners and groups with two to nine EPs are subject only to any upward or neutral adjustment determined under the quality-tiering methodology, while groups with 10 or more EPs would be subject to upward, neutral, or downward adjustments derived under the quality-tiering methodology. In other words, solo practitioners and groups with two to nine eligible professionals in Category 1 would be held harmless from any downward adjustments derived from the quality-tiering methodology for the CY17 VM.

For the CY16 value-based payment modifier, Category 1 will include:

- Groups of physicians that meet the criteria for satisfactory reporting of data on PQRS quality measures through the GPRO for the CY16 PQRS payment adjustment.
- Groups of physicians that do not register to participate in the PQRS as a group practice in CY14 and that have at least 50 percent of their EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the CY16 PQRS payment adjustment or, in lieu of satisfactory reporting, for satisfactory participation in a PQRS QCDR for the CY16 PQRS payment adjustment.
- For a group of physicians that is subject to the CY16 value-based payment modifier to be included in Category 1, the criteria for satisfactory reporting (or the criteria for satisfactory participation, in the case of the 50 percent option) must be met during the CY14 performance period for the PQRS CY16 payment adjustment.

Category 2 will include:

- Groups of physicians that are subject to the CY16 value-based payment modifier and do not fall within Category 1.

For CY16, under quality-tiering, each group receives two composite scores (quality and cost). CMS classifies each score into “high,” “average,” or “low” based on whether the score is one standard deviation from the mean score. This approach identifies statistically significant outliers and assigns them to their respective quality and cost tiers. The table below shows the quality-tiering payment adjustment amounts for 2016, based on 2014 performance.

CY 2016 VALUE-BASED PAYMENT MODIFIER AMOUNTS FOR THE QUALITY-TIERING APPROACH

Quality/cost	Low cost	Average cost	High cost (percent)
High quality	+2.0x*	+1.0x*	+0.0
Average quality	+1.0x*	+0.0%	-1.0
Low quality	+0.0%	-1.0%	-2.0

* Groups of physicians eligible for an additional +1.0x if reporting Physician Quality Reporting System quality measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores.

Approach to Setting the VM Adjustment Based on PQRS Participation for CY17

The final rule expands the application of the VM in CY17 to physicians and non-physician eligible professionals in groups, as well as those who are solo practitioners and physicians participating in the MSSP, Pioneer ACO Model, CPC Initiative, or other similar Innovation Center models or CMS initiatives during the 2015 performance period. CMS will use a similar two-category approach for the CY17 VM based on participation in the PQRS by groups and solo practitioners.

For purposes of the CY17 VM, Category 1 will include those groups that meet the criteria for satisfactory reporting of data on PQRS quality measures via the GPRO mechanisms for the CY17 PQRS payment adjustment. CMS will also include in Category 1 groups that do not register to participate in the PQRS as a group practice participating in the GPRO in CY15 and that have at least 50 percent of the group’s eligible professionals meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the CY17 PQRS payment adjustment, or, in lieu of satisfactory reporting, satisfactorily participate in a PQRS-qualified clinical data registry for the CY17 PQRS payment adjustment. Category 2 will include those groups and solo practitioners that are subject to the CY17 VM and do not fall within Category 1.

CMS is finalizing policies to:

1. Apply a -4.0 percent VM to groups with 10 or more eligible professionals that fall in Category 2
2. Apply a -2.0 percent VM to groups with two to nine eligible professionals and solo practitioners that fall in Category 2

Therefore, providers will need to satisfactorily report PQRS data to avoid an additional penalty. CY15 is the performance period for the CY17 payment adjustment period for the VM. CMS is finalizing the application of the quality-tiering methodology to all groups and solo practitioners in Category 1 for the VM for CY17. Groups with two to nine eligible professionals and solo practitioners would be subject only to upward or neutral adjustments derived under the quality-tiering methodology, while groups with 10 or more eligible professionals would be subject to

upward, neutral, or downward adjustments derived under the quality-tiering methodology. The potential adjustment amounts vary by group size.

Payment Adjustment Amount

CMS will continue to provide an additional upward payment adjustment of +1.0x to solo and group practices that care for high-risk beneficiaries (as evidenced by the average hepatocellular carcinoma risk score of the attributed beneficiary population). CMS believes this will alleviate commenters’ concerns that its proposals were too aggressive for smaller groups and solo practitioners that are new to the VM in CY 17, while continuing the gradual phase-in of the VM for groups with 10 or more eligible professionals with an emphasis on the importance of reporting under the PQRS program and improving the quality and efficiency of services provided to Medicare beneficiaries. Below, Tables 88 and 89, show the quality-tiering payment adjustment amounts for CY17 (based on CY15 performance).

TABLE 88—FINAL CY 2017 VM PAYMENT ADJUSTMENT AMOUNTS FOR GROUPS WITH TWO TO NINE ELIGIBLE PROFESSIONALS AND SOLO PRACTITIONERS

Cost/quality	Low quality	Average quality	High quality
Low cost	+0.0%	*+1.0x	*+2.0x
Average cost	+0.0%	+0.0%	*+1.0x
High cost	+0.0%	+0.0%	+0.0%

*Groups and solo practitioners eligible for an additional +1.0x if reporting measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores, where 'x' represents the upward payment adjustment factor.

TABLE 89—FINAL CY 2017 VM PAYMENT ADJUSTMENT AMOUNTS FOR GROUPS WITH TEN OR MORE ELIGIBLE PROFESSIONALS

Cost/quality	Low quality	Average quality	High quality
Low cost	+0.0%	*+2.0x	*+4.0x
Average cost	- 2.0%	+0.0%	*+2.0x
High cost	- 4.0%	- 2.0%	+0.0%

*Groups eligible for an additional +1.0x if reporting measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores, where 'x' represents the upward payment adjustment factor.

The upward payment adjustment factor (“x” in Tables 88 and 89) will be determined after the performance period has ended, based on the aggregate amount of downward payment adjustments. Since CMS is finalizing a policy to use the performance period to determine which groups and solo practitioners participate in the MSSP for purposes of calculating their VM in CY17, it is not finalizing its proposal to calculate preliminary payment adjustment factors (“x” in Tables 88 and 89) prior to the beginning of the payment adjustment period and then recalculating the payment adjustment factors after the final ACO participation list is completed. CMS is, however, finalizing its proposal that it may update the payment adjustment factors, depending on the outcome of the informal inquiry process described at section III.N.4.i of the final rule.

Performance Periods

CY13 is the initial performance period for the VM that will be applied in CY15. This means that CMS will use performance on quality and cost measures during CY13 to calculate the VM that will apply to items and services for which payment is made under the PFS during CY15. CMS will use performance on quality and cost measures in CY14 to calculate the VM that is applied to items and services for which payment is made under the PFS during CY16. In the CY14 PFS final rule, CMS adopted a policy that performance on quality and cost measures in CY15 will be used to calculate the VM that is applied to items and services for which payment is made under the PFS during CY17.

Quality Measures

In the CY14 PFS final rule, CMS aligned its policies for the VM for CY16 with the PQRS group reporting mechanisms available to groups in CY14 and the PQRS reporting mechanisms available to individual EPs in CY14. As such, data submitted by individual EPs or groups for quality reporting purposes through any of the PQRS individual or group reporting mechanisms in CY14 will be used for calculating the quality composite under the quality-tiering approach for the VM for CY16. CMS also established a policy to include three additional quality measures (outcome measures) for all groups of physicians subject to the VBPM:

- A composite of rates of potentially preventable hospital admissions for heart failure, chronic obstructive pulmonary disease, and diabetes
- A composite rate of potentially preventable hospital admissions for dehydration, urinary tract infections, and bacterial pneumonia
- Rates of an all-cause hospital readmissions measure

PQRS Quality Measures

CMS finalized its proposal to use all of the quality measures available to be reported under the various PQRS reporting mechanisms to calculate a group or solo practitioner's VM in CY17, to the extent that a group (or individual eligible professionals in the group, in the case of the "50 percent option") or solo practitioner submits data on these measures. Groups with two or more eligible professionals can elect to include the patient experience of care measures collected through the PQRS CAHPS survey for CY15 in their VM for CY17. CMS will continue to include the three outcome measures in the quality measures used for the VM in CY17. For groups that are assessed under the "50 percent option" for the CY17 VM, CMS will calculate the group's performance rate for each measure reported by at least one eligible professional in the group by combining the weighted average of the performance rates of those eligible professionals reporting the measure. Also, for these groups, where all of the eligible professionals who report as individuals under PQRS do so by satisfactorily participating in a PQRS-qualified clinical data registry in CY15, and CMS is unable to receive quality performance data for those eligible professionals, it will classify the group's quality composite score as "average" under the quality-tiering methodology. Because this is the same policy as for the CY 2016 payment adjustment period, CMS is also making a conforming revision to § 414.1270(b)(4).

Further, in cases where some EPs in these groups report data using a qualified clinical data registry and CMS is unable to obtain the data, but others in the group report data using the other PQRS reporting mechanisms for individuals, it will calculate the group's score based on the reported performance data that it obtained through those other PQRS reporting mechanisms. Beginning with the CY14 performance period, measures reported through a PQRS-qualified clinical data registry that are new to PQRS will not be included in the quality composite for the VM until such time as there are historical data to calculate benchmarks for them.

Including the MSPB Measure

The Medicare Spending Per Beneficiary (MSPB) measure is included in the cost composite beginning with the CY16 VBPM, with a CY14 performance period. CMS will use the MSPB amount as the measure's performance rate rather than converting it to a ratio, as is done under the Hospital Inpatient Quality Reporting and Value-Based Purchasing Programs. The MSPB measure will be added to the total per capita costs for all attributed beneficiaries domain and

equally weighted with the total per capita cost measure. It will not be added to the total per capita costs for all attributed beneficiaries with specific conditions domain. CMS is finalizing the method under which an MSPB episode will be attributed to a single group of physicians that provides the plurality of Part B services during the index admission, for the purpose of calculating that group's MSPB measure rate. CMS is finalizing a minimum of 20 MSPB episodes for inclusion of the MSPB measure in a physician group's cost composite.

Quality Measures for the Medicare Shared Savings Program

CMS is finalizing a policy to use the ACO Group Practice Reporting Option (GPRO) Web Interface measures and the MSSP ACO all-cause readmission measure to calculate a quality composite score for groups and solo practitioners who participate in an ACO under the MSSP. CMS is finalizing its proposal to apply the benchmark policy for quality measures for the VM as described under § 414.1250 to determine the standardized score for quality measures for groups and solo practitioners participating in ACOs under the MSSP.

Physician Feedback Program

Federal Register, pages 67965-67966

CMS is required to provide confidential reports to physicians who measure the resources involved in furnishing care to Medicare FFS beneficiaries. CMS is also authorized to include information on the quality of care furnished to Medicare FFS beneficiaries. In Sept. 2014, CMS made available the Quality and Resources Use Reports (QRURs) based on CY13 data to all physicians (that is, TINs of any size) even though groups with fewer than 100 eligible professionals will not be subject to the VM in CY15. These reports provide clinically meaningful and actionable information on several aspects of the performance of a group practice or solo practitioner. The reports present not only data assessing a group practice's or solo practitioner's performance on cost measures and information about the services and procedures contributing most to beneficiaries' costs, but also provide data on their performance on quality measures they report under the PQRS as well as the three outcome measures under § 414.1230. The reports are based on the VM policies that were finalized in the CY13 PFS final rule for physician payment adjustments under the VM beginning Jan. 1, 2015, and they provide groups with an opportunity to see how the policies adopted will apply to them.

More Information

The final rule was published in the Nov. 13, 2014, [Federal Register](#). Additional information regarding the MPFS is available on the [CMS website](#).

Appendix 1: Previously Finalized Policies for Public Reporting on Physician Compare

TABLE 48: Summary of Previously Finalized Policies for Public Reporting on Physician Compare

Data Collection Year	Public Reporting Year	Reporting Mechanism(s)	Quality Measures and Data for Public Reporting
2012	2013	Web Interface (WI), EHR, Registry, Claims	Include an indicator for satisfactory reporters under PQRS successful e-prescribers under eRx, and participants in the EHR Incentive Program.
2012	2014	WI	5 Diabetes Mellitus (DM) and Coronary Artery Disease (CAD) measures collected via the WI for group practices reporting under PQRS GPRO with a minimum sample size of 25 patients and Shared Savings Program ACOs.
2013	2014	WI, EHR, Registry, Claims	Include an indicator for satisfactory reporters under PQRS, successful e-prescribers under eRx, and participants in the EHR Incentive Program. Include an indicator for EPs who earn a PQRS Maintenance of Certification Incentive and EPs who report the PQRS Cardiovascular Prevention measures group in support of Million Hearts.
2013	Expected to be December 2014	WI	Up to 6 DM and 2 CAD measures collected via the GPRO WI for groups of 25 or more EPs and Shared Savings Program ACOs with a minimum sample size of 20 patients. Will include composites for DM and CAD, if feasible.
2013	Expected to be December 2014	WI	Up to 5 CG-CAHPS summary measures for groups of 100 or more EPs reporting under PQRS GPRO via the WI and up to 6 ACO CAHPS summary measures for Shared Savings Program ACOs.
2014	Expected to be 2015	WI, EHR, Registry, Claims	Include an indicator for satisfactory reporters under PQRS and participants in the EHR Incentive Program. Include an indicator for EPs who earn a PQRS Maintenance of Certification Incentive and EPs who report the PQRS Cardiovascular Prevention measures group in support of Million Hearts.
2014	Expected to be late 2015	WI, EHR, Registry, Administrative Claims	All measures reported via the GPRO WI, 13 EHR, and 16 Registry GPRO measures are also available for group practices of 2 or more EPs reporting under PQRS GPRO with a minimum sample size of 20 patients. Also, all Shared Savings Program ACO measures are available for public reporting. Include composites for DM and CAD, if feasible.
2014	Expected to be late 2015	WI, Certified Survey Vendor	Up to 12 CG-CAHPS summary measures for groups of 100 or more EPs reporting via the WI and group practices of 25 to 99 EPs reporting via a CMS-approved certified survey vendor, as well as 6 ACO CAHPS summary measures for Shared Savings Program ACOs reporting through the GPRO Web Interface or other CMS-approved tool or interface.
2014	Expected to be late 2015	Registry, EHR, or Claims	A sub-set of 20 PQRS measures submitted by individual EPs that align with those available for group reporting via the WI and that are collected through a Registry, EHR, or claims with a minimum sample size of 20 patients.
2014	Expected to be late 2015	Registry	Measures from the Cardiovascular Prevention measures group reported by individual EPs in support of the Million Hearts Initiative with a minimum sample size of 20 patients.

Appendix 2: Individual Reporting Criteria for 2017 PQRS Payment Adjustment

TABLE 50: Summary of Requirements for the 2017 PQRS Payment Adjustment: Individual Reporting Criteria for the Satisfactory Reporting of Quality Measures Data via Claims, Qualified Registry, and EHRs and Satisfactory Participation Criterion in QCDRs

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting/Satisfactory Participation Criteria
12-month (Jan 1– Dec 31, 2015)	Individual Measures	Claims	Report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50 percent of the eligible professional’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the eligible professional sees at least 1 Medicare patient in a face-to-face encounter, the eligible professional will report on at least 1 measure contained in the proposed cross-cutting measure set specified in Table 52. If less than 9 measures apply to the eligible professional, the eligible professional would report up to 8 measure(s), AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.
12-month (Jan 1– Dec 31, 2015)	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50 percent of the eligible professional’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the eligible professional sees at least 1 Medicare patient in a face-to-face encounter, the eligible professional will report on at least 1 measure contained in the proposed cross-cutting measure set specified in Table 52. If less than 9 measures apply to the eligible professional, the eligible professional would report up to 8 measure(s), AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.
12-month (Jan 1– Dec 31, 2015)	Individual Measures	Direct EHR Product or EHR Data Submission Vendor Product	Report 9 measures covering at least 3 of the NQS domains. If an eligible professional’s direct EHR product or EHR data submission vendor product does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional would be required to report all of the measures for which there is Medicare patient data. An eligible professional would be required to report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1– Dec 31, 2015)	Measures Groups	Qualified Registry	Report at least 1 measures group AND report each measures group for at least 20 patients, the majority (11 patients) of which are required to be Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted.
12-month (Jan 1– Dec 31, 2015)	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR	Qualified Clinical Data Registry (QCDR)	Report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, AND report each measure for at least 50 percent of the eligible professional’s patients. Of these measures, the eligible professional would report on at least 2 outcome measures, OR, if 2 outcomes measures are not available, report on at least 1 outcome measures and at least 1 of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety

Appendix 3: Final Criteria for Satisfactory Reporting of Quality Data via the GPRO for the 2017 PQRS payment Adjustment

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1–Dec 31, 2015)	25-99 eligible professionals	Individual GPRO Measures in the GPRO Web Interface	GPRO Web Interface	Report on all measures included in the web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group’s sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100 percent of assigned beneficiaries. In other words, we understand that, in some instances, the sampling methodology we provide will not be able to assign at least 248 patients on which a group practice may report, particularly those group practices on the smaller end of the range of 25–99 eligible professionals. If the group practice is assigned less than 248 Medicare beneficiaries, then the group practice must report on 100 percent of its assigned beneficiaries. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31, 2015)	25-99 eligible professionals and 100+ eligible professionals	Individual GPRO Measures in the GPRO Web Interface + CAHPS for PQRS	GPRO Web Interface + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor. In addition, the group practice must report on all measures included in the GPRO web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group’s sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100 percent of assigned beneficiaries. A group practice will be required to report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31, 2015)	2-99 eligible professionals	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the NQS domains. Of these measures, if a group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice would report on at least 1 measure in the cross-cutting measure set specified in Table 52. If less than 9 measures covering at least 3 NQS domains apply to the group practice, the group practice would report up to 8 measures covering 1–3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the group’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.
12-month (Jan 1–Dec 31, 2015)	2-99 eligible professionals and 100+ eligible professionals	Individual Measures + CAHPS for PQRS	Qualified Registry + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 of the NQS domains using the qualified registry. If less than 6 measures apply to the group practice, the group practice must report up to 5 measures. Of the

Appendix 3: Final Criteria for Satisfactory Reporting of Quality Data via the GPRO for the 2017 PQRS payment Adjustment - Cont.

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
	nals			additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, if any eligible professional in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice must report on at least 1 measure in the cross-cutting measure set specified in Table 52.
12-month (Jan 1– Dec 31, 2015)	2-99 eligible professionals	Individual Measures	Direct EHR Product or EHR Data Submission Vendor Product	Report 9 measures covering at least 3 domains. If the group practice’s direct EHR product or EHR data submission vendor product does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1– Dec 31, 2015)	2-99 eligible professionals and 100+ eligible professionals	Individual Measures + CAHPS for PQRS	Direct EHR Product or EHR Data Submission Vendor Product + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 of the NQS domains using the direct EHR product or EHR data submission vendor product. If less than 6 measures apply to the group practice, the group practice must report up to 5 measures. Of the additional 6 measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, a group practice would be required to report on at least 1 measure for which there is Medicare patient data.

Appendix 4: VM Implementation Table

Performance Year	VM Year	Group Size	Outcomes
2013 <i>(Quality-Tiering Optional)</i>	2015	100+ EPs	<ul style="list-style-type: none"> • Upward • No Adjustment • Downward Adjustment (-1.0%)
2014 <i>(Quality-Tiering Mandatory)</i>	2016	100+ EPs	<ul style="list-style-type: none"> • Upward Adjustment • No Adjustment • Downward Adjustment (-2.0%)
		10+ EPs	<ul style="list-style-type: none"> • Upward Adjustment (x% budget neutral) • No adjustment
2015 <i>(Quality-Tiering Mandatory)</i>	2017	10+ EPs	<p>PQRS reporters:</p> <ul style="list-style-type: none"> • Upward Adjustment (+4%) • No Adjustment • Downward Adjustment (max -4%) <p><i>Groups and solo practitioners receiving an upward adjustment are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25% of all beneficiary risk scores nationwide.</i></p> <p>Non-PQRS reporters:</p> <ul style="list-style-type: none"> • Automatic -4.0% downward adjustment
		2-9 EPs and Solo Practitioners	<p>PQRS reporters:</p> <ul style="list-style-type: none"> • Upward Adjustment (+2%) • No Adjustment <p>Non-PQRS Reporters:</p> <ul style="list-style-type: none"> • Automatic -2.0% downward adjustment