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# CY16 Medicare Physician Fee Schedule Proposed Rule Fact Sheet

## Overview

The Centers for Medicare & Medicaid Services (CMS) released a proposed rule with comment period in the July 15, 2015, *Federal Register* that would revise payment polices under the Medicare Physician Fee Schedule (PFS), and make other policy changes related to Medicare Part B payment. These proposed changes would be applicable to services furnished in calendar year 2016 (CY16). The rule also includes proposals associated with PFS payments, including the Physician Quality Reporting System (PQRS), the Physician Value-Based Payment Modifier (VM) and Physician Feedback Reporting Program, updates to the Physician Compare website, and the Electronic Health Record (EHR) Incentive Program. Also included in the proposal is the potential expansion of the Comprehensive Primary Care Initiative (CPC).

### Changes in Relative Value Unit Impacts

*Federal Register, page*s 41789, 41938-41939, 41714, 41702

**Proposed Update Summary:** The primary purpose of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), enacted into law on April 16, 2015, was to repeal the Medicare sustainable growth rate (SGR) and strengthen Medicare access by improving physician payments and making other improvements. This law established an update factor of 0.5 percent to PFS rates for CY16. CMS proposes to implement this update, which results in a conversion factor (CF) of **$36.1096** ($36.11) for CY16. This figure reflects a budget neutrality adjustment of 0.9999, along with the 0.5 percent update factor specified under MACRA. CMS notes that because CY16 represents a transition year in its new process of proposing values for new, revised, and misvalued codes in the proposed rule, rather than establishing them as interim final in the final rule with comment period, it will not be able to calculate a realistic estimate of the target amount at the time the proposed rule was published. Therefore, it did not incorporate the impact of the target into the calculation of the proposed conversion factor. It did, however, estimate the net reduction in expenditures as a result of proposed adjustments to the relative value established for misvalued codes in the proposed rule, not including the interim final changes that will be established in the CY16 PFS final rule. The net reduction is approximately 0.25 percent of the estimated amount of expenditures under the fee schedule for CY16.

*Anesthesia CF*

CMS estimates the CY16 anesthesia conversion factor (CF) to be **$22.6296** ($22.63), which reflects the 0.9999 budget neutrality adjustment, a 0.99602 anesthesia fee schedule adjustment practice expense, and malpractice (MP) adjustment, and the 0.5 percent update specified under the MACRA. For CY16, in order to appropriately update the MP resource costs for anesthesia, CMS proposes to make adjustments to the anesthesia conversion factor (CF) to reflect the updated premium information collected for the five-year relative value unit (RVU) review. CMS believes that payment rates for anesthesia should reflect MP resource costs relative to the rest of the PFS, including periodic updates to reflect changes over time.

## Resource-Based Practice Expense (PE) RVUs

*Federal Register*, pages 41689-41700

**Proposed Update Summary:** CMS discusses several CY15 proposals and revisions related to direct practice expense (PE) inputs for specific services. The proposed direct PE inputs are included in the proposed CY16 direct PE input database, which is available on its website under downloads for the CY16 PFS proposed rule with comment period at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html. CMS continues to work on revisions to the direct PE input database to provide the number of clinical labor minutes assigned for each task for every code in the database, instead of only including the number of clinical labor minutes for the pre-service, service, and post-service periods for each code. Under the proposal, CMS would implement a Protecting Access to Medicare Act of 2014 requirement that, for services that are not new or revised codes, applicable adjustments in work practice expense and malpractice RVUs must be phased in over a two-year period if the total RVUs for a service for a year would otherwise be decreased by an estimated 20 percent or more as compared to the total RVUs for the previous year. Although the Protecting Access to Medicare Act of 2014 required the phase-in of RVU reductions of 20 percent or more to begin for 2017, the Achieving a Better Life Experience Act now requires the phase-in to begin in CY16.

## Telehealth Services

*Federal Register,* pages 41781-41784

**Proposed Update Summary:** CMS received several requests in CY14 to add various services as Medicare telehealth services effective for CY16. CMS proposes to add the following services to the telehealth list on a category 1 basis for CY16:

- **CPT code 99356** - prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management (E/M) service)
- **CPT code 99357** - prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service
- **CPT codes 90963** - end-stage renal disease- (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
- **CPT code 90964** – ESRD-related services for home dialysis per full month, for patients 2–11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
- **CPT code 90965** – ESRD-related services for home dialysis per full month, for patients 12–19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
- **CPT code 90966** – ESRD-related services for home dialysis per full month, for patients 20 years of age and older

CMS believes that these services are sufficiently similar to psychiatric diagnostic procedures or office/outpatient visits currently on the telehealth list to qualify on a category 1 basis. The prolonged service codes can only be billed in conjunction with hospital inpatient and skilled

nursing facility (SNF) E/M codes, and of these, only subsequent hospital and subsequent nursing facility visit codes are on the list of Medicare telehealth services. Therefore, CPT codes 99356 and 99357 would only be reportable with codes for which limits of one subsequent hospital visit every three days via telehealth, and one subsequent nursing facility visit every thirty days, would continue to apply. Although CPT codes 90963, 90964, 90965, 90966 pertain to services for homebased dialysis, and a patient's home is not an authorized originating site for telehealth, CMS recognizes that many components of these services would be furnished from an authorized originating site and, therefore, can be furnished via telehealth.

CMS reminds interested stakeholders that it is currently soliciting public requests to add services to the list of Medicare telehealth services. To be considered during PFS rulemaking for CY17, these requests must be submitted and received by Dec. 31, 2015. CMS also proposes to add certified registered nurse anesthetists (CRNAs) as practitioners who may provide telehealth services. CRNAs were originally omitted because CMS did not believe they would furnish any of the approved telehealth services. However, the agency now notes that they are licensed to provide certain services on the telehealth list, including E/M services.

## Incident to Proposals: Billing Physician as the Supervising Physician and Ancillary Personnel Requirements

*Federal Register*, pages 41784-41786

**Proposed Update Summary:** CMS is proposing to revise the requirements for which physicians or other practitioners can bill for incident-to services. Specifically, CMS proposes to amend the regulation to state that the physician or other practitioner who bills for incident-to services must also be the physician or other practitioner who directly supervises the auxiliary personnel who provide the incident-to services. Also, to further clarify the meaning of the proposed amendment to the regulation, CMS is proposing to remove the last sentence from §410.26(b)(5) specifying that the physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) upon whose professional service the incident-to service is based. As a condition of Medicare payment, auxiliary personnel who, under the direct supervision of a physician or other practitioner, provide incident-to services to Medicare beneficiaries must comply with all applicable federal and state laws. This includes not having been excluded from Medicare, Medicaid, and all other federally funded healthcare programs by the Office of Inspector General (OIG). As such, CMS proposes to amend the regulation to explicitly prohibit auxiliary personnel from providing incident-to services who have either been excluded from Medicare, Medicaid, and all other federally funded healthcare programs by the OIG, or who have had their enrollment revoked for any reason. This proposed revision is an additional safeguard to ensure that excluded or revoked individuals are not providing incident-to services and supplies under the direct supervision of a physician or other authorized supervising practitioner.

## Chronic Care Management (CCM) Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

*Federal Register*, pages 41793-41797

**Proposed Update Summary**

*RHC and FQHC Payment Methodologies*

A rural health clinic (RHC) or federally qualified health center (FQHC) visit must be a face-to-face encounter between the patient and a RHC or FQHC practitioner during which time one or more services are furnished. RHCs are paid an all-inclusive rate (AIR) for medically-necessary medical and mental health services, and qualified preventive health services furnished on the same day (with some exceptions). On Oct. 1, 2014, FQHCs transitioned to a FQHC PPS system in which they are paid based on the lesser of a national encounter-based rate or their total adjusted charges. Both the AIR and FQHC PPS payment rates were designed to reflect all the services that a RHC or FQHC furnishes in a single day, regardless of the length or complexity of the visit or the number or type of practitioners seen.

*Payment for Chronic Care Management Services*

The proposed rule would provide an additional payment for the costs of Chronic Care Management (CCM) services that are not already captured in the RHC AIR or the FQHC PPS payment, beginning on Jan. 1, 2016. Services that are currently being furnished and paid under the RHC AIR or FQHC PPS payment methodology will not be affected by the ability of the RHC or FQHC to receive payment for additional services that are not included in the RHC AIR or FQHC PPS. RHCs and FQHCs cannot bill under the PFS for these services and individual practitioners working at RHCs and FQHCs cannot bill under the PFS these services while working at the RHC or FQHC. While many RHCs and FQHCs coordinate services within their own facilities, and may sometimes help to coordinate services outside their facilities, the type of structured care management services that are now payable under the PFS for patients with multiple chronic conditions, particularly for those who are transitioning from a hospital or SNF back into their communities, are not included in the RHC or FQHC payment.

*Proposed Payment Methodology and Billing Requirements*

The requirements CMS proposes for RHCs and FQHCs to receive payment for CCM services are consistent with those finalized in the CY15 PFS final rule with comment period for practitioners billing under the PFS, and are summarized in Table 17 of the proposal (***Appendix 1*** of this document). Under the proposal, CMS would establish payment, beginning on Jan. 1, 2016, for RHCs and FQHCs who furnish a minimum of 20 minutes of qualifying CCM services during a calendar month to patients with multiple (two or more) chronic conditions that are expected to last at least 12 months or until death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. The CPT code descriptor sets forth the eligibility guidelines for CCM services and will serve as the basis for potential medical review. An RHC or FQHC would be able to bill for CCM services furnished by, or incident to, a RHC or FQHC physician, nurse practitioner (NP), physician assistant (PA), or certified nurse midwife (CNM) for an RHC or FQHC patient once per month, and only one CCM payment per beneficiary per month can be paid. If another practice furnishes CCM services to a beneficiary, the RHC or FQHC cannot bill for CCM services for the same beneficiary for the same service period. CMS also proposes that transitional care management and any other program that provides additional payment for care management services (outside of the RHC AIR or FQHC

PPS payment) cannot be billed during the same service period. Payment for CCM services would be based on the PFS national average non-facility payment rate when CPT code 99490 is billed alone, or with other payable services on an RHC or FQHC claim. CCM payment to RHCs and FQHCs would be based on the PFS amount, but would be paid as part of the RHC and FQHC benefit, using the CPT code to identify that the requirements for payment are met and a separate payment should be made. CMS also proposes to waive the RHC and FQHC face-to-face requirements when CCM services are furnished to an RHC or FQHC patient. Coinsurance would be applied as applicable to FQHC claims, and coinsurance and deductibles would apply as applicable to RHC claims. RHCs and FQHCs would continue to be required to meet the RHC and FQHC conditions of participation and any additional RHC or FQHC payment requirements.

*Proposed Requirements for CCM Payment in RHCs and FQHCs*

RHCs and FQHCs are encouraged to focus on patients with high acuity and high risk when furnishing CCM services to eligible patients, including those who are returning to a community setting following discharge from a hospital or SNF. Consistent with beneficiary notification and consent requirements under the PFS, CMS proposes that the following requirements be met before the RHC or FQHC can furnish or bill for CCM services:

- The eligible beneficiary must be informed about the availability of CCM services from the RHC or FQHC and provide his or her written agreement to have the services provided

- The RHC or FQHC must document in the patient's medical record that all of the CCM services were explained and offered to the patient, and note the patient's decision to accept these services

- At the time the agreement is obtained, the eligible beneficiary must be informed that the agreement for CCM services could be revoked by him or her at any time either verbally or in writing, and the practitioner must explain the effect of a revocation of the agreement for CCM services

- The RHC or FQHC must provide a written or electronic copy of the care plan to the beneficiary and record this in the beneficiary's electronic medical record.

*Proposed Scope of CCM Services in RHCs and FQHCs*

All of the following scope-of-service requirements would have to be met to bill for CCM services:

- Initiation of CCM services during a comprehensive E/M, annual wellness visit, or Initial Preventive Physical Examination visit
- Continuity of care with a designated RHC or FQHC practitioner with whom the patient is able to get successive routine appointments
- Care management for chronic conditions
- A patient-centered plan of care document created by the RHC or FQHC practitioner furnishing CCM services in consultation with the patient, caregiver, and other key practitioners treating the patient to assure that care is provided in a way that is congruent with patient choices and values

- Creation of an electronic care plan that would be available 24 hours a day and seven days a week to all practitioners and providers within the FQHC or RHC who are furnishing CCM services whose time counts toward the time requirement for billing the CCM code
- Management of care transitions within health care, including referrals to other clinicians, visits following a patient visit to an emergency department, and visits following discharges from hospitals and SNFs
- Coordination with home- and community-based clinical service providers required to support a patient's psychosocial needs and functional deficits
- Secure messaging, internet, or other asynchronous non-face-to-face consultation methods for a patient and caregiver to communicate with the provider regarding the patient's care, in addition to the use of the telephone

*Proposed Electronic Health Records (EHR) Requirements*

CMS believes that the use of EHR technology that allows data sharing is necessary to assure that RHCs and FQHCs can effectively coordinate services with other practitioners for patients with multiple chronic conditions. Therefore, CMS proposes certified health information technology must be used for the recording of demographic information, clinical history, medications, and other scope of service requirements that reference a health or medical record. Also, RHCs and FQHCs must use technology certified to the edition(s) of certification criteria that is, at a minimum, acceptable for the EHR Incentive Programs as of December 31st of the year preceding each CCM payment year to meet certain core technology capabilities.

## Physician Quality Reporting System (PQRS)

*Federal Register*, pages 41815-41880

**Proposed Update Summary:** This section contains the proposed requirements for the PQRS. The proposed requirements primarily focus on CMS's proposals related to the 2018 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 2016 (that is, Jan. 1 through Dec. 31, 2016). In developing these proposals, CMS focused on aligning its requirements, to the extent appropriate and feasible, with other quality reporting programs, such as the Medicare EHR Incentive Program for Eligible Professionals, the VM, and the Medicare Shared Savings Program (MSSP). Additionally, CMS notes that it is beginning to emphasize the reporting of certain types of measures, such as outcome measures, as well as measures within certain National Quality Strategy (NQS) domains.

CMS is proposing to require the reporting of the CAHPS for the PQRS survey for groups of 25 or more EPs who register to participate in the PQRS GPRO and select the GPRO web interface as the reporting mechanism. In addition, it would continue to require the reporting of at least one applicable cross-cutting measure if an EP sees at least one Medicare patient. Furthermore, when reporting measures via a qualified clinical data registry (QCDR), CMS emphasizes the reporting of outcome measures, as well as resource use, patient experience of care, efficiency/appropriate use, or patient safety measures.

The PQRS includes the following reporting mechanisms: claims; qualified registry; EHR (including direct EHR products and EHR data submission vendor products); the GPRO web interface; certified survey vendors for CAHPS for PQRS survey measures; and the QCDR. The proposed rule changes the QCDR and qualified registry reporting mechanisms. CMS does not propose to make changes to the other PQRS reporting mechanisms.

*Proposed Changes to the Requirements for the QCDR*

In the proposal, CMS seeks to clarify issues related to QCDR self-nomination, as well as propose a change related to the requirements for an entity to become a QCDR. Specifically, CMS would open the QCDR self-nomination period on December 1 of the prior year to allow providers an additional month to self-nominate. In the CY14 PFS final rule, CMS established the requirement that, for an entity to become qualified for a given year, it must be in existence as of January 1 the year prior to the year for which it seeks to become a QCDR (for example, Jan. 1, 2013, to be eligible to participate for purposes of data collected in 2014). CMS received feedback from entities that this requirement is overly burdensome. To address these concerns while still ensuring that an entity seeking to become a QCDR is well established, beginning in 2016, CMS proposes to modify this requirement, such that the entity must be in existence as of January 1 the year for which it seeks to become a QCDR (for example, Jan. 1, 2016, to be eligible to participate for purposes of data collected in 2016).

Further, in lieu of submitting an attestation statement via email, beginning in 2016, CMS proposes to allow QCDRs to attest during the data submission period using a web-based check box mechanism. Also, instead of giving an entity wishing to become a QCDR until March 31 of the year in which it seeks to become a QCDR to submit measure information that it intends to report for the year, CMS proposes to require that all other documents that are necessary to analyze the vendor for qualification be provided at the time of self-nomination, that is, by no later than January 31 of the year in which it intends to participate in the PQRS as a QCDR. This will give CMS time to vet and analyze these vendors to determine whether they are fully ready to be qualified to participate. Beginning in 2016, A QCDR must also provide specific information to CMS at the time of self-nomination in order to meet data validation requirements. The MACRA authorizes CMS to create an option for EPs participating in the GPRO to report quality measures via a QCDR. As such, in addition to being able to submit quality measures data for individual EPs, CMS proposes that QCDRs also have the ability to submit quality measures data for group practices.

*Proposed Criteria for Satisfactory Reporting for Individual EPs for the 2018 PQRS Payment Adjustment*

The ACA provides that for covered professional services furnished by an EP during 2015 or any subsequent year, if the EP does not satisfactorily report data on quality measures for covered professional services for the quality reporting period for the year, the fee schedule amount for services furnished by the EP 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. For 2016 and subsequent years, the applicable percent is 98.0 percent.

Tables 20 and 21 of the proposed rule (***Appendix 3*** of this document)**,** reflects CMS's proposed criteria for satisfactory reporting or satisfactory participation in a QCDR, for the 2018 PQRS payment adjustment.

*Proposed Cross-Cutting Measures for 2016 Reporting and Beyond*

In the CY15 PFS final rule with comment period, CMS finalized a set of 19 cross-cutting measures for reporting in the PQRS for 2015 and beyond. In Table 22 of the rule (***Appendix 4*** of this document), CMS proposes four new measures to be added to the current PQRS crosscutting

measure set. These measures include:

- Preventive Care and Screening: Unhealthy Alcohol Use
- Breast Cancer Screening
- Falls: Risk Assessment
- Falls: Plan of Care

CMS's rationale for proposing each of these measures is found below the measure description.

*PQRS Measures Groups*
CMS proposes to add the following three new measures groups that will be available for reporting in the PQRS beginning in 2016.

- ***Multiple Chronic Conditions Measures Group:*** The addition of this measures group would specifically identify those providers that address the exponential complexity of treating the combination of these conditions rather than a sum of the individual conditions.

- ***Cardiovascular Prevention Measures Group (Millions Hearts):*** This measures group was removed for 2015 PQRS reporting due to clinical guideline changes that affected many of the measures. Given the efficacy of cardiovascular prevention on cardiovascular health, this measures group is being reconsidered with an adjustment to align with current clinical guidelines.

- ***Diabetic Retinopathy Measures Group:*** An increase in the frequency of Type 2 diabetes in the pediatric age group is associated with increased childhood obesity. The implications are significantly increased burdens of disability and complications associated with diabetes, including diabetic retinopathy. The addition of this measures group would help to address this significant public health problem by allowing for the comprehensive evaluation of provider performance and patient outcomes related to this disease.

In Tables 27, 28, and 29 of the rule, CMS provides the PQRS measure numbers for the measures.

## Medicare Shared Savings Program
*Federal Register, pages* 41184-41892

**Proposed Update Summary:** Under the proposed changes, CMS has identified a few policies related to the quality measures and quality performance standard that it is proposing in the rule. Specifically, it would add a new quality measure to be reported through the CMS web interface, and adopt a policy for addressing quality measures that no longer align with updated clinical guidelines or where the application of the measure may result in patient harm. In the CY15 PFS final rule with comment period, CMS finalized an updated measure set of 33 measures.

*Proposed New Measures*
CMS proposes to add one new measure to the Preventive Health domain, which would increase its current total number of measures from 33 to 34. Data collection for the new measure would occur through the CMS web interface. Table 31 (***Appendix 5*** of this document) lists the Shared

Savings Program quality measure set, including the one proposed measure that would be used to assess ACO quality starting in 2016:

- **Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**

This measure was developed by CMS in collaboration with other federal agencies and the Million Hearts Initiative and is intended to support the prevention and treatment of cardiovascular disease by measuring the use of statin therapies, according to the updated clinical guidelines for patients with high cholesterol. The measure reports the percentage of beneficiaries who were prescribed or were already on statin medication therapy during the measurement year, and who fall into any of the following three categories:

- High-risk adult patients aged greater than or equal to 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease
- Adult patients aged greater than or equal to 21 years with any fasting or direct Low-Density Lipoprotein Cholesterol (LDL–C) level that is greater than or equal to 190 mg/dL
- Patients aged 40 to 75 years with a diagnosis of diabetes with a fasting or direct LDL–C level of 70 to 189 mg/dL who were prescribed or were already on statin medication therapy during the measurement year

The measure contains multiple denominators to align with the updated clinical guidelines for cholesterol targets and would replace the low-density lipid control measures previously retired from the measure set. CMS proposes that the multiple denominators will be equally weighted when calculating the performance rate. CMS is seeking comment on whether the measure should be considered a single measure with weighted denominators, or three measures, given that multiple denominators were developed to adhere to the updated clinical guidelines. Under the proposed rule, CMS would increase the size of the oversample for this measure from the normal 616 beneficiaries for CMS web interface reporting to an oversample of 750 or more beneficiaries. CMS is proposing such an oversample size for this measure to account for reporting on the multiple denominators, and to ensure a sufficient number of beneficiaries meet the measure denominators for reporting. The consecutive reporting requirement for measures reported through the CMS web interface would remain at 248 beneficiaries. The measure would be pay for reporting for two years, and then phase into pay for performance in the third year of the agreement period, as seen in Table 31 of the rule. CMS seeks comment on whether stakeholders believe the measure should be pay for reporting for the entire agreement period due to the application of multiple denominators for a single measure.

As a result of this proposed addition, each of the four domains would include the following number of quality measures:

- Patient/Caregiver Experience of Care - 8 measures
- Care Coordination/Patient Safety - 10 measures
- Preventive Health - 9 measures
- At Risk Population - 7 measures (including 6 individual measures and a two-component diabetes composite measure)

Table 32 of the proposed rule (***Appendix 6*** of this document) provides a summary of the number of measures by domain and the total points and domain weights that will be used for scoring purposes with the proposed additional measure in the At-Risk Population domain. The total possible points for the Preventive Health domain would increase from 16 points to 18 points. Otherwise, the current methodology for calculating an ACO's overall quality performance score would continue to apply. CMS is also seeking comment on whether the proposed Statin Therapy measure, with multiple denominators, should be scored at more than two points if commenters believe this measure should be treated as multiple measures within the Preventive Health domain instead of a single measure. For instance, the measure could be scored as three points—one point for each of the three denominators—due to the clinical importance of prevention and treatment of cardiovascular disease, and the complexity of the measure.

*Proposed Policy Change*

There have been circumstances where changes in clinical guidelines result in quality measures within the Shared Savings Program quality measure set no longer aligning with best clinical practice. In the CY15 PFS final rule with comment period, CMS retired measures that were no longer consistent with updated clinical guidelines for cholesterol targets, but was unable to finalize retirement of the measures for the 2014 reporting year due to the timing of the guideline updates and rulemaking cycle. Given the frequency of changes that occur in scientific evidence and clinical practice, CMS proposes to adopt a general policy under which it will maintain measures as pay-for reporting, or revert pay-for-performance measures to pay-for-reporting measures, if the measure owner determines the measure no longer meets best clinical practices due to clinical guideline updates, or when clinical evidence suggests that continued measure compliance and collection of the data may result in harm to patients. This flexibility will enable the agency to respond more quickly to clinical guideline updates that affect measures without waiting until a future rulemaking cycle to retire a measure or revert to pay for reporting. Therefore, CMS is proposing to add this as a new provision at §425.502(a)(5).

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

Since the November 2011 Shared Savings Program final rule, CMS has continued to review the quality measures used for the Shared Savings Program to ensure that they are up to date with current clinical practice and are aligned with the GPRO web interface reporting for PQRS. Based on the reviews, CMS has identified a number of proposed measure additions, deletions, and other revisions that it believes would be appropriate for the Shared Savings Program. Under the proposed measure revisions, ACOs would be assessed on 37 measures annually, an increase of four measures. However, CMS believes the measures chosen are more outcome-oriented and would ultimately reduce the reporting burden on ACOs. In the proposal, CMS provides a detailed description of proposed changes that would be effective for the 2015 reporting period, and would be reported by ACOs in early 2016.

*Request for Comment Related to Use of Health Information Technology*

In the November 2011 final rule, CMS included a measure related to the use of health IT under the Care Coordination/Patient Safety domain: the percent of PCPs within an ACO who successfully qualify for an EHR Incentive Program incentive. In the CY15 PFS final rule with comment period, CMS finalized a proposal to change the name and specification of this measure to *''Percent of PCPs who Successfully Meet Meaningful Use Requirements''* in order to reflect the transition from incentive payments to downward payment adjustments in 2015. CMS believes this name will more accurately depict successful use and adoption of EHR technology.

While it is not proposing any changes to the current measure at this time, CMS is seeking comment on how this measure might evolve in the future to ensure it is incentivizing and rewarding providers for continuing to adopt and use more advanced health IT functionality, and broadening the set of providers across the care continuum that have adopted these tools.

*Assignment of Beneficiaries Based on Certain Evaluation and Management Services in SNFs*
CMS proposes certain revisions to the assignment of beneficiaries to ACOs under the Shared Savings Program. In the November 2014 proposed rule for the Shared Savings Program, CMS welcomed comment from stakeholders on the implications of retaining certain evaluation and management codes used for physician services furnished in SNFs and other nursing facility settings (CPT codes 99304 through 99318) in the definition of primary care services. Some commenters objected to inclusion of SNF visit codes, believing a SNF is more of an extension of the inpatient setting rather than a component of the community-based primary care setting. As a result, these commenters believe that ACOs are often inappropriately assigned patients who have had long SNF stays but would not otherwise be aligned to the ACO, and with whom the ACO has no clinical contact after their SNF stay. Therefore, CMS is proposing to amend its definition of primary care services for purposes of the Shared Savings Program, to exclude services billed under CPT codes 99304 through 99318 when the claim includes the point of service (POS) 31 modifier. CMS recognizes that SNF patients are shorter stay patients who are generally receiving continued acute medical care and rehabilitative services. If CMS finalizes this proposal, it anticipates applying this revised definition of primary care services for purposes of determining ACO eligibility during the application cycle for the 2017 performance year, which occurs during 2016, and the revision would then be applicable for all ACOs starting with the 2017 performance year.

*Assignment of Beneficiaries to ACOs that Include Electing Teaching Amendment Hospitals*
CMS proposes to amend the definition of primary care services by adding HCPCS code G0463 for services furnished in an electing teaching amendment (ETA) hospital to the definition of primary care services that will be applicable for performance year 2016 and subsequent performance years. CMS would add a new paragraph to the statute to provide that when considering services furnished by physicians in ETA hospitals in the assignment methodology, it would use an estimated amount based on the amounts payable under the PFS for similar services in the geographic location in which the ETA hospital is located as a proxy for the amount of the allowed charges for the service. In this case, because G0463 is not payable under the PFS, CMS is proposing to use the weighted mean amount payable under the PFS for CPT codes in the range 99201 through 99205 and 99211 through 99215 as a proxy for the amount of the allowed charges for HCPCS code G0463 when submitted by ETA hospitals.

The weights needed to impute the weighted mean PFS payment rate for HCPCS code G0463 would be derived from the relative number of services furnished at the national level for CPT codes 99201 through 99205 and 99211 through 99215. Additional details regarding computation of the proxy amount for G0463 would be provided through sub-regulatory guidance. Additionally, because CMS is able to consider claims submitted by ETA hospitals as part of the assignment process, it also proposes to add ETA hospitals to the list of ACO participants that are eligible to form an ACO that may apply to participate in the Shared Savings Program.

*Overview of Existing Policies for the Physician Value-Based Payment Modifier (VM)*
In the CY13 PFS final rule with comment period, CMS finalized policies to phase-in the VM by applying it beginning Jan. 1, 2015, to Medicare PFS payments to physicians in groups of 100 or more EPs). Subsequently, in the CY14 PFS final rule with comment period, CMS finalized policies to continue the phase-in of the VM by applying it starting Jan. 1, 2016, to payments under the Medicare PFS for physicians in groups of 10 or more EPs. Then, in the CY15 PFS final rule with comment period, the agency finalized policies to complete the phase-in of the VM by applying it starting Jan. 1, 2017, to payments under the Medicare PFS for physicians in groups of two or more EPs, and physician solo practitioners. Beginning on Jan. 1, 2018, the VM will only apply to select nonphysician EPs in groups with two or more EPs, and to certain nonphysician EPs who are solo practitioners. In 2018, the quality score under the VM will be based on 2016 PQRS reporting.

*Application of the VM to Nonphysician EPs Who Are PAs, NPs, CNSs, and CRNAs*
CMS will apply the VM beginning in CY18 to the items and services billed under the PFS by all of the physicians and nonphysician eligible professionals (EPs) who bill under a group's Tax identification number (TIN). During the payment adjustment period, all of the nonphysician EPs who bill under a group's TIN will be subject to the same VM that will apply to the physicians who bill under that TIN. In the CY15 PFS final rule with comment period, CMS finalized that it will apply the VM beginning in the CY18 payment adjustment period to all nonphysician EPs in groups with two or more EPs and to nonphysician EPs who are solo practitioners. However, after the enactment of MACRA in April 2015, CMS believed it would not be appropriate to apply the VM in CY18 to any nonphysician EP who is not a physician assistant (PA), nurse practitioner (NP), certified nurse specialist (CNS), or Certified registered nurse anesthetist (CRNA) since payment adjustments under the merit-based incentive payment system would not apply to them until 2021. Therefore, CMS proposes to apply the VM in the CY18 payment adjustment period to nonphysician EPs who are PAs, NPs, CNSs, and CRNAs in groups with two or more EPs, and to PAs, NPs, CNSs, and CRNAs who are solo practitioners. As defined by the statute, physicians include doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors.

*VM Adjustment Based on PQRS Participation*
In the CY15 PFS final rule, CMS established that, beginning with the CY17 payment adjustment period, the VM will apply to physicians in groups with two or more EPs and physicians who are solo practitioners based on the applicable performance period. In that rule, CMS also adopted a two-category approach for the CY17 VM based on participation in the PQRS by groups and solo practitioners. CMS proposes to use a similar two category approach for the CY18 VM based on participation in the PQRS by groups and solo practitioners.

For the CY18 VM, CMS proposes that Category 1 would include those groups that meet the criteria outlined in Table 21 (***Appendix 7*** of this document) of the rule to avoid the PQRS payment adjustment for CY18 as a group practice participating in the PQRS GPRO. CMS also proposes to include in Category 1, groups that have at least 50 percent of the group's EPs meet the criteria as outlined in Table 20 of the proposed rule (***Appendix 8*** of this document) to avoid the PQRS payment adjustment for CY18 as individuals. CMS notes that the proposed criteria for groups to be included in Category 1 for the CY18 VM differ from the criteria it finalized for the

CY17 VM. Under the policy for the CY17 VM, CMS will only consider whether at least 50 percent of a group's EPs met the criteria to avoid the PQRS payment adjustment as individuals if the group did not register to participate in a PQRS GPRO. In contrast, under its proposal for the CY18 VM, in determining whether a group would be included in Category 1, it would consider whether the 50 percent threshold has been met regardless of whether the group registers for a PQRS GPRO.

CMS would also revise the criteria for groups to be included in Category 1 for the CY17 VM, if it is operationally feasible for its systems to utilize data reported through a mechanism other than the one through which a group registered to report under PQRS GPRO. Lastly, CMS proposes to include in Category 1 for the CY18 VM those solo practitioners that meet the criteria to avoid the CY18 PQRS payment adjustment as individuals, as proposed in Table 20 of the proposed rule. Category 2 would include those groups and solo practitioners that are subject to the CY18 VM and do not fall within Category 1.

*Quality Tiering Model*

The quality-tiering model compares the quality of care composite with the cost composite to determine the VM. To determine a group practice's VM score, the quality-tiering model calculates two composite scores. One is based on the quality measures reported by the group, and the other is based on cost measures calculated by CMS. The quality-tiering model compares the quality of care composite score with the cost composite score, and classifies both scores into high, average, and low performance categories. For the CY18 VM, CMS proposes to continue to apply the quality-tiering methodology to all groups and solo practitioners in Category 1. As such, solo practitioners would be subject to upward, neutral, or downward adjustments derived under the quality-tiering methodology, with the exception finalized in the CY15 PFS final rule, that groups consisting only of nonphysician EPs, and solo practitioners who are nonphysician EPs will be held harmless from downward adjustments under the quality-tiering methodology in CY18. Based on CMS's proposal to apply the CY18 VM to only certain types of nonphysician EPs, only the PAs, NPs, CNSs, and CRNAs in groups consisting of nonphysician EPs, and those physicians who are solo practitioners will be held harmless from downward adjustments under the quality-tiering methodology in CY18. For groups with between two to nine EPs, and physician solo practitioners, CMS believes it is appropriate to begin both the upward and downward payment adjustments under the quality-tiering methodology for the CY18 VM because they will have adequate data to improve performance on the quality and cost measures that will be used to calculate the VM in CY18.

*Payment Adjustments*

Section 1848(p) of the Act does not specify the amount of payment that should be subject to the adjustment for the VM; however, it does require that the VM be implemented in a budget-neutral manner. The table below, (Table 33 of the proposal) shows the proposed quality-tiering payment adjustment amounts for CY18 for physicians, PAs, NPs, CNSs, and CRNAs in groups with 10 or more EPs.

TABLE 33—CY 2018 VM AMOUNTS FOR THE QUALITY-TIERING APPROACH FOR PHYSICIANS, PAS, NPS, CNSS, AND CRNAS IN GROUPS WITH TEN OR MORE EPS

| 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 PQRS quality 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 34 (below) of the proposal shows the proposed quality-tiering payment adjustment amounts for CY18 for physicians, PAs, NPs, CNSs, and CRNAs in groups with between two to nine EPs and physician solo practitioners.

TABLE 34—CY 2018 VM AMOUNTS FOR THE QUALITY-TIERING APPROACH FOR PHYSICIANS, PAS, NPS, CNSS, AND CRNAS IN GROUPS WITH 2 TO 9 EPS AND PHYSICIAN SOLO PRACTITIONERS

| Cost/quality | Low quality | Average quality | High quality |
|---|---|---|---|
| Low cost ..... | +0.0% | *+1.0x | *+2.0x |
| Average cost | −1.0% | +0.0% | *+1.0x |
| High cost ..... | −2.0% | −1.0% | +0.0% |

*Groups and solo practitioners eligible for an additional +1.0x if reporting PQRS quality 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 following table (Table 35 of the proposal) shows the proposed quality-tiering payment adjustment amounts for CY18 for PAs, NPs, CNSs, and CRNAs in groups that consist of nonphysician EPs and PAs, NPs, CNSs, and CRNAs who are solo practitioners.

TABLE 35—CY 2018 VM AMOUNTS FOR THE QUALITY-TIERING APPROACH FOR PAS, NPS, CNSS, AND CRNAS IN GROUPS CONSISTING OF NONPHYSICIAN EPS AND PAS, NPS, CNSS, AND CRNAS WHO ARE 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 are eligible for an additional +1.0x if reporting PQRS quality 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.

CMS believes its proposed approach would reward groups and solo practitioners that provide high-quality/low-cost care. CMS would use CY16 as the performance period for the VM adjustments that will apply during CY18.

*High-Risk Beneficiaries*

Beginning in the CY17 payment adjustment period, CMS proposes to apply an additional upward adjustment of +1.0x to groups and solo practitioners that participated in high performing Shared Savings Program ACOs that cared for high-risk beneficiaries during the performance period.

*Quality Measures*

In the CY15 PFS final rule with comment period, CMS aligned its policies for the VM for CY17 with the PQRS group reporting mechanisms, and the PQRS reporting mechanisms available to individual EPs in CY15. It also finalized its policy to continue to include the three outcome measures in the quality measures used for the VM in CY17. These measures include:

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

Under the proposal, CMS would continue calculating these three additional quality outcome measures that are included in the quality composite score. CMS would also continue to include in the VM all of the PQRS GPRO reporting mechanisms available to groups and individual EPs for the PQRS reporting periods in CY16. These reporting mechanisms are described in Tables 20 and 21 of the proposed rule. Additionally, CMS proposes to continue to use all of the quality

measures (described in Tables 22 through Table 30 of the proposed rule) that are available to be reported under these various PQRS reporting mechanisms to calculate a group or solo practitioner's VM in CY18 to the extent that a group (or individual EPs in the group, in the case of the ''50 percent option'') or solo practitioner submits data on these measures. For group practices that successfully report PQRS data as individual EPs, CMS proposes to continue calculating the group's performance on measures by combining the weighted average of rates for the individual EPs that report the measure.

*Cost Composite*

A group or solo practitioner subject to the VM receives 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. CMS proposes that a group or solo practitioner subject to the VM would 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 that meets the minimum number of cases required for the measure to be included in the calculation of the cost composite.

*Quality Composite Score*

A quality measure must have 20 or more cases in order to be included in the calculation of the quality composite; however, beginning with the CY17 payment adjustment period, the all-cause hospital readmissions measure must have 200 or more cases in order to be included. Individual EPs and groups that do not have at least one measure meeting the minimum volume requirement would be scored as "average quality" under the quality- tiering methodology.

*2018 VBPM Adjustment based on 2016 PQRS Participation*

CMS proposes to continue its policy to designate all groups and solo practitioners under one of two categories for the purposes of determining payment adjustments under the VM in 2018. Specifically, CMS categorizes groups of physicians eligible for the VM into two categories:

***Category 1*** - Includes groups of physicians that do one of the following:

- Meet the criteria for satisfactory reporting of data on PQRS quality measures through the GPRO for the CY16 PQRS payment adjustment
- Do not register to participate in the PQRS as a group practice in CY14 and have at least 50 percent of the group's 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, satisfactorily participate in a PQRS-qualified clinical data registry for the CY16 PQRS payment adjustment

For a group of physicians that is subject to the CY16 VM to be included in Category 1, the criteria for satisfactory reporting (or the criteria for satisfactory participation, if the PQRS-QCDR mechanism is selected) must be met during the CY14 reporting period for the PQRS CY16 payment adjustment.

***Category 2*** - Includes those groups of physicians that:

- Are subject to the CY16 VM and do not fall within Category 1. For those groups of physicians in Category 2, the VM for CY16 is -2.0 percent.

For the 2016 performance year, CMS proposes to include EPs and groups participating in a Medicare Shared Savings Program ACO that do not successfully report quality measures data in Category 2.

*Benchmarks for electronically-reported Clinical Quality Measures*

Because the electronic clinical quality measures (eCQM) version of a measure may differ from the specifications of the all-mechanism benchmark, to which it is currently compared, CMS proposes to change its benchmark policy to indicate that eCQMs, as identified by their CMS eMeasure IDs, which are distinct from the CMS/PQRS measure numbers for other reporting mechanisms, will be recognized as distinct measures under the VM. As such, it would exclude eCQM measures from the overall benchmark for a given measure, and create separate eCQM benchmarks, based on the CMS eMeasure ID. CMS proposes to make this change beginning with the CY16 performance period, for which the eCQM benchmarks would be calculated based on CY15 performance data.

*Medicare Spending per Beneficiary Measure for VBPM Cost Composite*

For performance year 2015 affecting 2017 payments, CMS proposes to increase the episode count from a minimum of 20 episodes to at least 100 episodes, meaning a TIN would have to have at least 100 Medicare Spending per Beneficiary (MSPB) episodes for the measure to be included in the cost composite. Although this reduces the number of groups and solo practitioners for whom CMS would be able to include an MSPB calculation in the cost composite (from 29,190 to 8,543 based on 2013 data), it does not believe it should use the measure in calculating the cost composite if it is not reliable at the 20-episode minimum.

*Additional Upward Payment Adjustment to High Quality Participant Shared Savings Program ACOs*

CMS proposes to apply an additional upward payment adjustment of +1.0x to Shared Savings Program ACO participant TINs that are classified as ‘‘high quality’’ under the quality-tiering methodology, if the attributed patient population of the ACO in which the TINs participated during the performance period has an average beneficiary risk score that is in the top 25 percent of all beneficiary risk scores nationwide, as determined under the VM methodology.

*Expansion of the Informal Inquiry Process to Allow VBPM Corrections*

CMS proposes to maintain the current informal review submission period occurring during the 60 days following release of the Quality and Resource Use Reports (QRURs) for the 2016 VM and subsequent years. It believes that this will allow sufficient time for it to process the majority of the requests before finalizing the adjustment factor.

*Physician Feedback Program*

In fall 2015, CMS plans to expand the Physician Feedback Program by making QRURs, containing data on cost and quality performance during CY14, available to all solo practitioner EPs and groups of EPs of all sizes, as identified by TIN, including nonphysician EP solo practitioners and groups comprising nonphysician EPs. CMS also plans to make the 2014 QRURs available to Shared Savings Program ACO participant TINs and groups that include one or more EPs who participated in a Pioneer ACO or the CPC Initiative. The reports will contain valuable information about a TIN’s actual performance during CY14 on the quality and cost measures that will be used to calculate the CY16 VM. For physicians in groups of 10 or more, the 2014 QRURs will provide information on how a group’s quality and cost performance will affect their Medicare payments in 2016 through the application of the VM based on performance

in 2014. CMS will continue to refine the QRURs based on stakeholder feedback, and invites comment on which aspects of the QRURs reports have been most useful, and how it can improve access to and actionability of performance reports.

*Application of the VM to Solo Practitioners and Groups with EPs Who Participate in the Pioneer ACO Model and CPC Initiative*

CMS received many comments on the proposals made in the CY15 PFS proposed rule indicating that it should exempt Pioneer ACO Model and CPC Initiative participants from the VM. A few commenters also suggested that the application of the VM to Innovation Center initiatives should be waived under section 1115A of the Act. In considering potential policy options to include in the proposed rule, CMS agreed with the commenters that it would be appropriate to use the waiver authority with regard to the Pioneer ACO Model and CPC Initiative. Accordingly, CMS proposes to waive application of the VM as required by section 1848(p) of the Act for groups and solo practitioners, as identified by TIN, if at least one EP who billed for PFS items and services under the TIN during the applicable performance period for the VM participated in the Pioneer ACO Model or CPC Initiative during the performance period. CMS did not waive the VM for participants of the MSSP.

*Waiver for Participation in the Comprehensive ESRD Care Initiative, Oncology Care Model, and Next Generation ACO Model*

CMS proposes that in the event it finalizes its proposal to waive application of the VM for the Pioneer ACO Model and CPC Initiative, it would also waive application of the VM for the Next Generation ACO Model, the Oncology Care Model, and the Comprehensive ESRD Care Initiative, as similar models if at least one EP who billed for PFS items and services under the TIN during the CY16 performance period for the VM participated in the model during the CY16 performance period.

## Electronic Health Record Incentive Program

*Federal Register*, pages 41880-41881

In the CY15 PFS final rule with comment period, CMS finalized its proposal for the Medicare EHR Incentive Program that, beginning in CY15, EPs are not required to ensure that their certified EHR technology (CEHRT) products are recertified to the most recent version of the electronic specifications for the clinical quality measures (CQMs). CMS notes that, although it is not requiring recertification, EPs must still report the most recent version of the electronic specifications for the CQMs if they choose to report CQMs electronically for the Medicare EHR Incentive Program. In the FY16 IPPS proposed rule, CMS stated that it anticipates proposing to require EPs, eligible hospitals, and critical access hospitals (CAHs) seeking to report CQMs electronically as part of meaningful use under the EHR Incentive Programs for 2016 to adhere to the additional standards and constraints on the QRDA standards for electronic reporting as described in the CMS Quality Reporting Document Architecture (QRDA) Implementation Guide.

CMS also stated that it anticipated revising the definition of ‘‘certified electronic health record technology’’ to require certification to the optional portion of the 2015 Edition CQM reporting criterion in the CY16 Medicare PFS proposed rule. Accordingly, to allow providers to upgrade to 2015 Edition CEHRT before 2018, CMS proposes to revise the CEHRT definition for 2015 through 2017 to require that EHR technology is certified to report CQMs, in accordance with the optional certification, in the format that it can electronically accept (CMS’s ‘‘form and manner’’

requirements) if certifying to the 2015 Edition ‘‘CQMs—report’’ certification criterion. Specifically, this would require technology to be certified to the QRDA Category I and III standard. CMS notes that the proposed CEHRT definition for 2015 through 2017 included in the Stage 3 proposed rule published on March 30, 2014, allows providers to use 2014 Edition or 2015 Edition certified EHR technology.

CMS also proposes to revise the CEHRT definition for 2018 and subsequent years to require that EHR technology is certified to report CQMs, in accordance with the optional certification, in the format that CMS can electronically accept. Specifically, this would require technology to be certified to the QRDA Category I and III standards also). These proposed revisions would apply for EPs, eligible hospitals, and CAHs. CMS proposes these amendments to ensure that providers participating in PQRS and the EHR Incentive Programs under the 2015 Edition possess EHRs that have been certified to report CQMs according to the format that it requires for submission.

## Physician Self-Referral Updates

*Federal Register*, pages 41909-41930

The proposed rule would update the physician self-referral regulations to accommodate delivery and payment system reform, reduce burden, and facilitate compliance. CMS proposes to revise several definitions in its regulations to improve clarity and ensure proper application of its policies. The proposed rule also expands the regulations to establish two new exceptions and clarifies certain regulatory terminology and requirements.

The definitions that CMS proposes to revise include the following:

*Physician-owned hospitals*

The ACA amended the rural provider and hospital ownership or investment interest exceptions to the physician self-referral law to impose additional restrictions on physician ownership and investment in hospitals. Specifically, a physician-owned hospital is required to disclose the fact that it is partially owned or invested in by physicians on its website, and in any public advertising for the hospital. CMS proposes to provide physician-owned hospitals more certainty regarding the forms of communication that require a disclosure statement, and the types of language that would constitute a sufficient statement of physician ownership or investment. For the public website disclosure requirement, CMS lists things that would be excluded from its definition of “public website”, including, social media websites and social media communications used to develop social and professional contacts; electronic patient payment portals; electronic patient care portals; and electronic health information exchanges. CMS also proposes to define public advertising for the hospital, for purposes of the physician self-referral law, as any public communication paid for by the hospital that is primarily intended to persuade individuals to seek care at the hospital. The agency also proposes that any language that would put a reasonable person on notice that the hospital may be physician-owned is deemed a sufficient statement of physician ownership or investment.

*Bona Fide Investment Level*

CMs refers to the percentage of ownership or investment interests held by physicians in a hospital as the ‘‘*bona fide* investment level’’, and such percentage that was set as of March 23, 2010, as the ‘‘baseline *bona fide* investment level.”Currently, CMS calculates the bona fide investment level based on the number of physician owners or investors who self-refer to the hospital. In the rule, CMS proposes to revise its policy articulated in the CY11 OPPS final rule to

require that the baseline *bona fide* investment level and the *bona fide* investment level include both direct and indirect ownership and investment interests held by a physician if he or she satisfies the definition of ''physician,'' regardless of whether the physician refers patients to the hospital (and therefore, irrespective of whether he or she is a ''referring physician'') for purposes of its regulatory definition of ownership or investment interest. CMS would delay the effective date of the new regulation to allow physician-owned hospitals to have sufficient time to come into compliance with the new policy.

*Remuneration*

A compensation arrangement between a physician (or an immediate family member of such physician) and a designated health services (DHS) entity implicates the referral and billing prohibitions of the physician self-referral law. The term ''compensation arrangement'' as any arrangement involving any ''remuneration'' between a physician (or an immediate family member of such physician) and an entity. CMS proposes to revise the definition of ''remuneration'' to make it clear that the item must be used solely for one or more of the six purposes listed in the statute. CMS also clarifies that that a physician's use of a hospital's resources (for example, examination rooms, nursing personnel, and supplies) when treating hospital patients would not constitute remuneration under the physician self-referral law, if the hospital bills the appropriate payor for the resources and services it provides, and the physician bills the payer for his or her professional fees only. CMS does not believe that such an arrangement involves remuneration between the parties, because the physician and the DHS entity do not provide items, services, or other benefits to one another.

*Compensation Arrangements –''Stand in the Shoes"*

CMS's intent under this arrangement currently remains, that only physicians who stand in the shoes of their physician organization are considered parties to an arrangement for purposes of the signature requirements of the exceptions. CMS proposes to clarify that, for all purposes other than the signature requirements, all physicians in a physician organization are considered parties to the compensation arrangement between the physician organization and the DHS entity.

*Signature Requirements*

Several compensation arrangement exceptions to the physician self-referral law require that an arrangement be signed by the parties. Under the current rule, if the failure to comply with the signature requirement is inadvertent, the parties must obtain the required signature(s) within 90 days. If the failure to comply is not inadvertent, the parties must obtain the required signature(s) within 30 days. In the FY09 IPPS final rule, CMS stated that it would evaluate its experience with the related regulation and propose more or less restrictive modifications at a later date. CMS now proposes to modify the current regulation to allow parties 90 days to obtain the required signatures, regardless of whether or not the failure to obtain the signature(s) was inadvertent.

In the rule, CMS also proposes the following new exceptions:

1. *Timeshare Arrangements*: CMS proposes this new exception that would protect timeshare arrangements that meet certain criteria. Under the exception, the arrangement would have to be set out in writing, signed by the involved parties, and specify the premises, equipment, personnel, items, supplies, and services that it covers. The arrangement is between a hospital or physician organization (licensor) and a physician (licensee) for the use of the licensor's premises, equipment, personnel, items, supplies, or services used predominantly to furnish E/M services to the physician's patients. The proposed

exception would apply only to timeshare arrangements where the licensor is a hospital or physician organization; it would not protect arrangements where the licensor is another type of DHS entity. Excluded from the protection of the exception would be the license of advanced imaging equipment, radiation therapy equipment, and clinical and pathology laboratory equipment. The proposed new exception would also not be available to protect part-time exclusive use office space lease arrangements.

2. *Assistance to Employ Non-physician Practitioners*
CMS proposes a limited exception for hospitals, FQHCs, and RHCs that wish to provide remuneration to a physician to assist with the employment of a non-physician practitioner. The proposed exception would apply only where the non-physician practitioner is a *bona fide* employee of the physician receiving the remuneration from the hospital (or of the physician's practice), and the purpose of the employment is to provide primary care services to patients of the physician practice. Under this exception, CMS is proposing to define ''non-physician practitioner,'' to include only PAs, NPs, CNs, and CNMs. The exception would not protect arrangements for assistance to a physician to employ a CRNA. In addition, this proposed exception includes a cap on the amount of remuneration from the hospital to the physician, and a requirement that the hospital may not provide assistance for a period longer than the first two consecutive years of the non-physician practitioner's employment by the physician.

## Potential Expansion of the Comprehensive Primary Care (CPC) Initiative

*Federal Register*, pages 41881-41884

In the CPC Initiative, CMS is collaborating with commercial payers and state Medicaid offices to test a payment model consisting of non-visit based per-beneficiary-per-month care management payments and shared savings opportunities. Practices receive a monthly non-visit based care management fee for each Medicare FFS beneficiary and, in cases where the state Medicaid agency is participating, for each Medicaid FFS beneficiary. Practices also receive non-visit based care management payments from other participating CPC payers and are expected to combine CPC revenues across payers to support a whole-practice care delivery transformation strategy. CMS is offering each CPC practice the opportunity to share net savings generated from improved care to Medicare beneficiaries attributable to the practice. The HHS Secretary has the authority to expand (including implementation on a nationwide basis) through rulemaking the duration and scope of a model that is being tested under section 1115A(b) of the Act. CMS does not propose to expand the CPC initiative at this time, but requests comments on the following considerations for any potential expansion of the initiative:

*Practice readiness*:

- The proportion of primary care practices ready for the expansion transformation expectations, and whether readiness varies systematically for differently structured practices
- *Practice standards and reporting:* The value and operational burden of the current CPC Milestones approach, including the current system of quarterly reporting via a web portal
- *Practice groupings:* Whether any potential expansion should be limited to existing CPC regions, or include new geographic regions
- *Interaction with state primary care transformation initiatives:* Whether a potential expansion of the CPC initiative could and should exist in parallel in a state with a

separate state-led primary care transformation effort, especially if Medicare is participating in that effort

- *Learning activities:* The willingness and ability of existing state and regional primary care or patient-centered medical home learning collaboratives to support practices in a potential expansion of the CPC initiative
- *Payer and self-insured employer readiness:* Whether currently participating payers in the CPC initiative are ready to expand their current investment in CPC
- *Medicaid:* Whether state Medicaid agencies would be willing to participate in a potential expanded CPC initiative for their fee-for-service enrollees, and whether Medicaid managed care plans would be willing to participate in a potential expanded CPC initiative
- *Quality reporting: Whether p*ractices are ready to report eCQMs, and payer interest in using practice site level data rather than their own enrollees' information for performance- based payments, including shared savings, in a potential expansion of the CPC initiative
- *Interaction with the CCM fee:* How payment for CCM services might interact with a potential expansion of the CPC initiative, and affect practice interest in participation
- *Provision of data feedback to practices:* How CMS can best provide actionable data to support quality improvement and promote attention to total cost of care under a potential expansion.

## More Information

The final rule was published in the July 15 2015, *Federal Register*. Additional information regarding the MPFS is available on the CMS website.

## *Appendix 1: Proposed Requirements for RHCs and FQHCs to Receive Payment for CCM Services*

TABLE 17—SUMMARY OF PROPOSED CCM SCOPE OF SERVICE ELEMENTS AND BILLING REQUIREMENTS

| CCM Scope of service/billing requirements | Health IT requirements |
|---|---|
| Initiation of CCM services at an AWV, IPPE, or a comprehensive E/M visi. | None. |
| Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination, and ongoing clinical care. | Structured recording of demographics, problems, medications, medication allergies, and creation of structured clinical summary records using CCM certified technology. |
| Access to CCM services 24/7 (providing the beneficiary with a means to make timely contact with the RHC or FQHC to address his or her urgent chronic care needs regardless of the time of day or day of the week. | None. |
| Continuity of care with a designated RHC or FQHC practitioner with whom the beneficiary is able to get successive routine appointment. | None. |
| CCM services for chronic conditions including systematic assessment of the beneficiary's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of beneficiary self-management of medication. | None. |
| Creation of a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues. Share the care plan as appropriate with other practitioners and providers. | Must at least electronically capture care plan information; make this information available on a 24/7 basis to all practitioners within the RHC or FQHC whose time counts towards the time requirement for the practice to bill for CCM services; and share care plan information electronically (other than by fax) as appropriate with other practitioners, providers, and caregivers. |
| Provide the beneficiary with a written or electronic copy of the care plan and document its provision in the electronic medical record. | Document provision of the care plan as required to the beneficiary in the EHR using CCM certified technology. |
| Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities. | Format clinical summaries according to CCM certified technology. Not required to use a specific tool or service to exchange/transmit clinical summaries, as long as they are transmitted electronically (other than by fax). |
| Coordination with home and community based clinical service providers | Communication to and from home and community based providers regarding the patient's psychosocial needs and functional deficits must be documented in the patient's medical record using CCM certified technology. |
| Enhanced opportunities for the beneficiary and any caregiver to communicate with the RHC or FQHC regarding the beneficiary's care through not only telephone access, but also through the use of secure messaging, internet or other asynchronous non face-to-face consultation methods. | None. |
| Beneficiary consent—Inform the beneficiary of the availability of CCM services and obtain his or her written agreement to have the services provided, including authorization for the electronic communication of his or her medical information with other treating providers. | |
| Document in the beneficiary's medical record that all of the CCM services were explained and offered, and note the beneficiary's decision to accept or decline these services. | |
| Document the beneficiary's written consent and authorization in the EHR using CCM certified technology. | Document the beneficiary's written consent and authorization in the EHR using CCM certified technology. |
| Beneficiary consent—Inform the beneficiary of the right to stop the CCM services at any time (effective at the end of the calendar month) and the effect of a revocation of the agreement on CCM services. | None. |
| Beneficiary consent—Inform the beneficiary that only one practitioner can furnish and be paid for these services during a calendar month. | None. |

## *Appendix 2 – Proposed Physician Compare Measure and Participation Data*

TABLE 19—SUMMARY OF PROPOSED MEASURE AND PARTICIPATION DATA FOR PUBLIC REPORTING

| Data collection year* | Publication year* | Data type | Reporting mechanism | Proposed quality measures and data for public reporting |
|---|---|---|---|---|
| 2016 | 2017 | 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 Cardiovascular Prevention measures group proposed under PQRS in support of Million Hearts. |
| 2016 | 2018 | PQRS, PQRS, GPRO. | Web Interface, EHR, Registry, Claims. | Include an indicator for individual EPs and group practices who receive an upward adjustment for the VM. |
| 2016 | 2017 | PQRS, GPRO | Web Interface, EHR, Registry. | All 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.<br>Publicly report an item-level benchmark, as appropriate. |
| 2016 | 2017 | ACO | Web Interface, Survey Vendor Claims. | All measures reported by Shared Savings Program ACOs, including CAHPS for ACOs. |
| 2016 | 2017 | CAHPS for PQRS | CMS-Specified Certified CAHPS Vendor. | All CAHPS for PQRS measures for groups of 2 or more EPs who meet the specified sample size requirements and collect data via a CMS-specified certified CAHPS vendor. |
| 2016 | 2017 | PQRS | Registry, EHR, or Claims | All PQRS measures for individual EPs collected through a registry, EHR, or claims.<br>Publicly report an item-level benchmark, as appropriate. |
| 2016 | 2017 | QCDR data | QCDR | All individual EP and group practice QCDR measures. |
| 2016 | 2017 | Utilization data | Claims | Utilization data for individual EPs in the downloadable database. |
| 2016 | 2017 | PQRS, PQRS, GPRO. | Web Interface, EHR, Registry, Claims. | The following data for group practices and individual EPs in the downloadable database:<br>• The VM quality tiers for cost and quality, noting if the group practice or EP is high, low, or neutral on cost and quality per the VM.<br>• A notation of the payment adjustment received based on the cost and quality tiers.<br>• An indication if the individual EP or group practice was eligible to but did not report quality measures to CMS. |

*Note that these data are proposed to be reported annually. The table only provides the first year in which these proposals would begin on an annual basis, and such dates also serve to illustrate the data collection year in relation to the publication year. Therefore, after 2016, 2017 data would be publicly reported in 2018, 2018 data would be publicly reported in 2019, etc.

## *Appendix 3: Criteria for Satisfactory Reporting or Satisfactory Participation in a QCDR, for the 2018 PQRS Payment Adjustment*

TABLE 20—SUMMARY OF PROPOSED REQUIREMENTS FOR THE 2018 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, 2016). | 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 EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the EP sees at least 1 Medicare patient in a face-to-face encounter, the EP will report on at least 1 measure contained in the PQRS cross-cutting measure set. If less than 9 measures apply to the EP, the EP would report on each measure that is applicable), 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, 2016). | 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 EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the EP sees at least 1 Medicare patient in a face-to-face encounter, the EP will report on at least 1 measure contained in the PQRS cross-cutting measure set. If less than 9 measures apply to the EP, the EP would report on each measure that is applicable, 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, 2016). | Individual Measures. | Direct EHR Product or EHR Data Submission Vendor Product. | Report 9 measures covering at least 3 of the NQS domains. If an EP'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 EP would be required to report all of the measures for which there is Medicare patient data. An EP would be required to report on at least 1 measure for which there is Medicare patient data. |
| 12-month (Jan 1–Dec 31, 2016). | 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, 2016). | 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 EP's patients. Of these measures, the EP 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: Criteria for Satisfactory Reporting or Satisfactory Participation in a QCDR, for the 2018 PQRS Payment Adjustment - Continued*

TABLE 21—SUMMARY OF PROPOSED REQUIREMENTS FOR THE 2018 PQRS PAYMENT ADJUSTMENT: GROUP PRACTICE REPORTING CRITERIA FOR SATISFACTORY REPORTING OF QUALITY MEASURES DATA VIA THE GPRO

| Reporting period | Group practice size | Measure type | Reporting mechanism | Satisfactory reporting criteria |
|---|---|---|---|---|
| 12-month (Jan 1–Dec 31, 2016). | 25+ EPs (if CAHPS for PQRS does not apply). | 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 EPs. 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, 2016). | 25+ EPs (if CAHPS for PQRS applies). | 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.<br>Please note that, if the CAHPS for PQRS survey is applicable to a group practice who reports quality measures via the GPRO web interface, the group practice must administer the CAHPS for PQRS survey in addition to reporting the GPRO web interface measures. |
| 12-month (Jan 1–Dec 31, 2016). | 2+ EPs ..... | 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 PQRS cross-cutting measure set. If less than 9 measures covering at least 3 NQS domains apply to the group practice, the group practice would report on each measure that is applicable to the group practice, 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. |

## *Appendix 3: Criteria for Satisfactory Reporting or Satisfactory Participation in a QCDR, for the 2018 PQRS Payment Adjustment - Continued*

| | | | | |
|---|---|---|---|---|
| 12-month (Jan 1–Dec 31, 2016). | 2+ EPs that elect CAHPS for PQRS. | 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 the CAHPS for PQRS survey, 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 on each measure that is applicable to the group practice. Of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, if any EP 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 PQRS cross-cutting measure set. |
| 12-month (Jan 1–Dec 31, 2016). | 2+ EPs ..... | 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 all of the measures for which there is Medicare 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, 2016). | 2+ EPs that elect CAHPS for PQRS. | 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 all of the measures for which there is Medicare patient data. 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. |

| Reporting period | Group practice size | Measure type | Reporting mechanism | Satisfactory reporting criteria |
|---|---|---|---|---|
| 12-month (Jan 1–Dec 31, 2016). | 2+ EPs ..... | 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 group practice's patients. Of these measures, the group practice 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 4: Proposed CY16 PQRS Crosscutting Measures*

**TABLE 22: Proposed Individual Quality Cross-Cutting Measures for the PQRS to be Available for Satisfactory Reporting via Claims, Registry, and HER beginning in 2016**

| NQF/ PQRS | CMS E-Measure ID | NQS Domain | Measure Title and Description[v] | Measure Steward | Other Quality Reporting Programs |
|---|---|---|---|---|---|
| 2152/ N/A | N/A | Community/ Population Health | **Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user.<br><br>**Rationale**: This measure has been proposed as a cross-cutting measure for PQRS for CY 2016 as it represents a screening assessment for unhealthy alcohol use that most EPs may perform, assess, and document to ensure maintenance for this risk, and is applicable to most Medicare adult patients. | American Medical Association – Physician Consortium for Performance Improvement | |
| 2372/ 112 | 125v3 | Effective Clinical Care | **Breast Cancer Screening:** Percentage of women 50 through 74 years of age who had a mammogram to screen for breast cancer within 27 months.<br><br>**Rationale**: This measure has been reportable through PQRS for 8 years and was finalized for reporting through claims, registry, EHR, GPRO and measures group in the PQRS in the CY 2013 PFS final rule (77 FR 69227).<br><br>This measure has been proposed as a cross-cutting measure for PQRS for CY 2016 as it represents a screening assessment for breast cancer that most EPs may perform, assess, and document to ensure maintenance for this risk, and is applicable to most Medicare female adult patients. | National Committee for Quality Assurance | ACO/ MU2 |
| 0101/ 154 | N/A | Patient Safety | **Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months.<br><br>**Rationale**: This measure has been reportable through PQRS for 7 years and was finalized for reporting through claims and registry in the PQRS in the CY 2013 PFS final rule (77 FR 69232). In the CY 2015 PFS final rule, this measure was finalized for the addition of measures group reporting.<br><br>This measure has been proposed as a cross-cutting measure for PQRS for CY 2016 PFS as it is applicable to a variety of physican specialties and should be integrated into the standard of care for providers who serve patients with a history of falls. | National Committee for Quality Assurance/ American Medical Association – Physician Consortium for Performance Improvement | |
| 0101/ 155 | N/A | Communication and Care Coordination | **Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months.<br><br>**Rationale**: This measure has been reportable through PQRS for 7 years and was finalized for reporting through claims and registry in the PQRS in the CY 2013 PFS final rule (77 FR 69232). In the CY 2015 PFS final rule, this measure was finalized for the addition of measures group reporting.<br><br>This measure has been proposed as a cross-cutting measure for PQRS for CY 2016 as it is applicable to a variety of physican specialties and should be integrated into the standard of care for providers who serve patients with a history of falls. | National Committee for Quality Assurance/ American Medical Association – Physician Consortium for Performance Improvement | |

[v] Measure details including titles, descriptions and measure owner information may vary during a particular program year. This is due to the timing of measur specification preparation and the measure versions used by the various reporting options/methods. Please refer to the measure specifications that apply for eac of the reporting options/methods for specific measure details.

## *Appendix 5 - Quality Performance Standards Measures that ACOs Must Meet for Shared Savings*

TABLE 31—MEASURES FOR USE IN ESTABLISHING QUALITY PERFORMANCE STANDARDS THAT ACOS MUST MEET FOR SHARED SAVINGS

| Domain | ACO Measure No. | Measure title | New measure | NQF #/measure steward | Method of data submission | Pay for performance phase-in R—Reporting P—Performance | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | PY1 | PY2 | PY3 |
| AIM: Better Care for Individuals | | | | | | | | |
| Patient/ Caregiver Experience | ACO–1 | CAHPS: Getting Timely Care, Appointments, and Information. | ..... | NQF #0005, AHRQ. | Survey ..... | R | P | P |
| | ACO–2 | CAHPS: How Well Your Doctors Communicate. | ..... | NQF #0005, AHRQ. | Survey ..... | R | P | P |
| | ACO–3 | CAHPS: Patients' Rating of Doctor. | ..... | NQF #0005, AHRQ. | Survey ..... | R | P | P |
| | ACO–4 | CAHPS: Access to Specialists | ..... | NQF #N/A, CMS/AHRQ. | Survey ..... | R | P | P |
| | ACO–5 | CAHPS: Health Promotion and Education. | ..... | NQF #N/A, CMS/AHRQ. | Survey ..... | R | P | P |
| | ACO–6 | CAHPS: Shared Decision Making. | ..... | NQF #N/A, CMS/AHRQ. | Survey ..... | R | P | P |
| | ACO–7 | CAHPS: Health Status/Functional Status. | ..... | NQF #N/A, CMS/AHRQ. | Survey ..... | R | R | R |
| | ACO–34 | CAHPS: Stewardship of Patient Resources. | ..... | NQF #N/A, CMS/AHRQ. | Survey ..... | R | P | P |
| Care Coordination/Safety. | ACO–8 | Risk-Standardized, All Condition Readmission. | ..... | Adapted NQF #1789, CMS. | Claims ..... | R | R | P |
| | ACO–35 | Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM). | ..... | NQF #TBD, CMS. | Claims ..... | R | R | P |
| | ACO–36 | All-Cause Unplanned Admissions for Patients with Diabetes. | ..... | NQF#TBD, CMS. | Claims ..... | R | R | P |
| | ACO–37 | All-Cause Unplanned Admissions for Patients with Heart Failure. | ..... | NQF#TBD, CMS. | Claims ..... | R | R | P |
| | ACO–38 | All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions. | ..... | NQF#TBD, CMS. | Claims ..... | R | R | P |
| | ACO–9 | Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (AHRQ Prevention Quality Indicator (PQI) #5). | ..... | Adapted NQF #0275, AHRQ. | Claims ..... | R | P | P |
| | ACO–10 | Ambulatory Sensitive Conditions Admissions: Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8 ). | ..... | Adapted NQF #0277, AHRQ. | Claims ..... | R | P | P |
| | ACO–11 | Percent of PCPs who Successfully Meet Meaningful Use Requirements. | ..... | NQF #N/A, CMS. | EHR Incentive Program Reporting. | R | P | P |
| | ACO–39 | Documentation of Current Medications in the Medical Record. | ..... | NQF #0419, CMS. | CMS Web Interface. | R | P | P |
| | ACO–13 | Falls: Screening for Future Fall Risk. | ..... | NQF #0101, NCQA. | CMS Web Interface. | R | P | P |

***Appendix 5 - Quality Performance Standards Measures that ACOs Must Meet for Shared Savings (Cont.)***

AIM: Better Health for Populations

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Preventive Health. | ACO–14 | Preventive Care and Screening: Influenza Immunization. | ..... | NQF #0041, AMA–PCPI. | CMS Web Interface. | R | P | P |
| | ACO–15 | Pneumonia Vaccination Status for Older Adults. | ..... | NQF #0043, NCQA. | CMS Web Interface. | R | P | P |
| | ACO–16 | Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up. | ..... | NQF #0421, CMS. | CMS Web Interface. | R | P | P |
| | ACO–17 | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. | ..... | NQF #0028, AMA–PCPI. | CMS Web Interface. | R | P | P |
| | ACO–18 | Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan. | ..... | NQF #0418, CMS. | CMS Web Interface. | R | P | P |
| | ACO–19 | Colorectal Cancer Screening ... | ..... | NQF #0034, NCQA. | CMS Web Interface. | R | R | P |
| | ACO–20 | Breast Cancer Screening ..... | ..... | NQF #NA, NCQA. | CMS Web Interface. | R | R | P |
| | ACO–21 | Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented. | ..... | CMS ..... | CMS Web Interface. | R | R | P |
| | ACO–42 | Statin Therapy for the Prevention and Treatment of Cardiovascular Disease. | X | NQF #TBD, MUC ID: X3729, CMS. | CMS Web Interface. | R | R | P |

| Domain | ACO Measure No. | Measure title | New measure | NQF #/measure steward | Method of data submission | Pay for performance phase-in R—Reporting P—Performance | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | PY1 | PY2 | PY3 |
| Clinical Care for At Risk Population—Depression. | ACO–40 | Depression Remission at Twelve Months. | ..... | NQF #0710, MNCM. | CMS Web Interface. | R | R | R |
| Clinical Care for At Risk Population—Diabetes. | ACO–27 | Diabetes Composite (All or Nothing Scoring): ACO–27: Diabetes Mellitus: Hemoglobin A1c Poor Control. | ..... | NQF #0059, NCQA (individual component). | CMS Web Interface. | R | P | P |
| | ACO–41 | ACO–41: Diabetes: Eye Exam | ..... | NQF #0055, NCQA (individual component). | CMS Web Interface. | R | P | P |
| Clinical Care for At Risk Population—Hypertension. | ACO–28 | Hypertension (HTN): Controlling High Blood Pressure. | ..... | NQF #0018, NCQA. | CMS Web Interface. | R | P | P |
| Clinical Care for At Risk Population—Ischemic Vascular Disease. | ACO–30 | Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic. | ..... | NQF #0068, NCQA. | CMS Web Interface. | R | P | P |
| Clinical Care for At Risk Population —Heart Failure. | ACO–31 | Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD). | ..... | NQF #0083, AMA–PCPI. | CMS Web Interface. | R | R | P |
| Clinical Care for At Risk Population—Coronary Artery Disease. | ACO–33 | Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy—for patients with CAD and Diabetes or Left Ventricular Systolic Dysfunction (LVEF<40%). | ..... | NQF # 0066, ACC. | CMS Web Interface. | R | R | P |

## *Appendix 6 – Domain Measures and the Total Points and Domain Weights within Quality Performance Standard*

TABLE 32—NUMBER OF MEASURES AND TOTAL POINTS FOR EACH DOMAIN WITHIN THE QUALITY PERFORMANCE STANDARD

| Domain | Number of individual measures | Total measures for scoring purposes | Total possible points | Domain weight (%) |
|---|---|---|---|---|
| Patient/Caregiver Experience | 8 | 8 individual survey module measures | 16 | 25 |
| Care Coordination/Patient Safety | 10 | 10 measures. Note that the EHR measure is double-weighted (4 points). | 22 | 25 |
| Preventive Health | 9 | 9 measures | 18 | 25 |
| At-Risk Population | 7 | 6 individual measures, plus a 2-component diabetes composite measure, scored as one. | 12 | 25 |
| Total in all Domains | 34 | 33 | 68 | 100 |

## *Appendix 7 - Proposed Requirements for the 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria*

TABLE 21—SUMMARY OF PROPOSED REQUIREMENTS FOR THE 2018 PQRS PAYMENT ADJUSTMENT: GROUP PRACTICE REPORTING CRITERIA FOR SATISFACTORY REPORTING OF QUALITY MEASURES DATA VIA THE GPRO

| Reporting period | Group practice size | Measure type | Reporting mechanism | Satisfactory reporting criteria |
|---|---|---|---|---|
| 12-month (Jan 1–Dec 31, 2016). | 25+ EPs (if CAHPS for PQRS does not apply). | 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 EPs. 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, 2016). | 25+ EPs (if CAHPS for PQRS applies). | 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.<br>Please note that, if the CAHPS for PQRS survey is applicable to a group practice who reports quality measures via the GPRO web interface, the group practice must administer the CAHPS for PQRS survey in addition to reporting the GPRO web interface measures. |
| 12-month (Jan 1–Dec 31, 2016). | 2+ EPs ..... | 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 PQRS cross-cutting measure set. If less than 9 measures covering at least 3 NQS domains apply to the group practice, the group practice would report on each measure that is applicable to the group practice, 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. |

## *Appendix 7 - Proposed Requirements for the 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria (Cont.)*

| | | | | |
|---|---|---|---|---|
| 12-month (Jan 1–Dec 31, 2016). | 2+ EPs that elect CAHPS for PQRS. | 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 the CAHPS for PQRS survey, 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 on each measure that is applicable to the group practice. Of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, if any EP 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 PQRS cross-cutting measure set. |
| 12-month (Jan 1–Dec 31, 2016). | 2+ EPs ..... | 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 all of the measures for which there is Medicare 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, 2016). | 2+ EPs that elect CAHPS for PQRS. | 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 all of the measures for which there is Medicare patient data. 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. |

| Reporting period | Group practice size | Measure type | Reporting mechanism | Satisfactory reporting criteria |
|---|---|---|---|---|
| 12-month (Jan 1–Dec 31, 2016). | 2+ EPs ..... | 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 group practice's patients. Of these measures, the group practice 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 8 – Proposed Requirements for 2018 PQRS Payment Adjustment: Individual Reporting Criteria*

TABLE 20—SUMMARY OF PROPOSED REQUIREMENTS FOR THE 2018 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, 2016). | 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 EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the EP sees at least 1 Medicare patient in a face-to-face encounter, the EP will report on at least 1 measure contained in the PQRS cross-cutting measure set. If less than 9 measures apply to the EP, the EP would report on each measure that is applicable), 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, 2016). | 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 EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the EP sees at least 1 Medicare patient in a face-to-face encounter, the EP will report on at least 1 measure contained in the PQRS cross-cutting measure set. If less than 9 measures apply to the EP, the EP would report on each measure that is applicable, 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, 2016). | Individual Measures. | Direct EHR Product or EHR Data Submission Vendor Product. | Report 9 measures covering at least 3 of the NQS domains. If an EP'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 EP would be required to report all of the measures for which there is Medicare patient data. An EP would be required to report on at least 1 measure for which there is Medicare patient data. |
| 12-month (Jan 1–Dec 31, 2016). | 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, 2016). | 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 EP's patients. Of these measures, the EP 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. |