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CY16 Medicare Physician Fee Schedule Final Rule Fact Sheet

Overview

The Centers for Medicare & Medicaid Services (CMS) released a final rule with comment period in the, Nov. 16, 2015, *Federal Register* that will revise payment polices under the Medicare Physician Fee Schedule (PFS) and make other policy changes related to Medicare Part B payment. These final changes will be applicable to services furnished in calendar year 2016 (CY16). The final rule also includes updates 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 rule is the potential expansion of the Comprehensive Primary Care Initiative (CPC).

Changes in Relative Value Unit (RVU) Impacts

Federal Register, pages 71357-71360

Final Update Summary: CMS estimates the CY16 PFS conversion factor (CF) to be **$35.83**, which reflects the budget neutrality adjustment, the 0.5 percent update adjustment factor specified under The Medicare Access and CHIP Reauthorization Act (MACRA), and the 0.77 percent target recapture amount required under Section 1848(c)(2)(O)(iv) of the Social Security Act (The Act). The table following table shows the calculation of the CY16 CF.

TABLE 60—CALCULATION OF THE CY 2016 PFS CONVERSION FACTOR

Conversion factor in effect in CY 2015		35.9335
Update Factor	0.5 percent (1.005).	
CY 2016 RVU Budget Neutrality Adjustment	−0.02 percent (0.9998).	
CY 2016 Target Recapture Amount	−0.77 percent (0.9923).	
CY 2016 Conversion Factor		35.8279

Anesthesia CF

CMS estimates the CY16 anesthesia CF to be **$22.33**, which reflects the same adjustments, with the addition of anesthesia-specific practice expense (PE) and Malpractice (MP) adjustments. The following table shows the calculation of the CY16 CF.

TABLE 61—CALCULATION OF THE CY 2016 ANESTHESIA CONVERSION FACTOR

CY 2015 National Average Anesthesia Conversion Factor		22.6093
CY 2016 RVU Budget Neutrality Adjustment	−0.02 percent (0.9998).	
CY 2016 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment.	−0.445 percent (0.99555).	
CY 2016 Target Recapture Amount	−0.79 percent (0.9923).	
CY 2016 Conversion Factor		22.3309

Resource-Based Practice Expense (PE) RVUs

Federal Register, pages 7090-70938

Final Update Summary: The final direct PE inputs for CY16 are displayed in the final CY16 direct PE input database, which is available on the CMS website under the downloads for the CY16 final rule at www.cms.gov/physicianfeesched/. The inputs displayed there have also been used in developing the CY16 PE RVUs as displayed in Addendum B of the final rule.

Under the final rule, CMS will 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. CMS will identify significant reductions in RVUs based on a comparison of RVUs before application of budget neutrality adjustment. CMS will phase in 19 percent of the reduction in value in the first year and the remainder of the reduction in the second year, as proposed.

Applying the adjustments to the PE RVUs for all individual codes in order to effect the appropriate phase-in amount is the most straightforward and fair approach to implementing the two-year phase-in of significant reductions of total RVUs. Therefore, CMS finalized this aspect of the phase-in methodology as proposed. The list of codes subject to the phase-in and the associated RVUs that result from this methodology are available on the CMS website under downloads for the CY16 PFS final rule with comment period at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html

Telehealth Services

Federal Register, pages 71060-71064

Final Update Summary: CMS received several requests in CY14 to add various services as Medicare telehealth services effective for CY16. CMS will 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 30 days, would continue to apply. Although CPT codes 90963, 90964, 90965, and 90966 pertain to services for home-based dialysis, and a patient's home is not an authorized originating site for telehealth, CMS recognizes that many components of these services could be furnished from an authorized originating site and, therefore, can be furnished via telehealth.

CMS will also 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, CRNAs in some states are licensed to furnish certain services on the telehealth list, including E/M services.

Section 1834(m)(2)(B) of the Act establishes the Medicare telehealth originating site facility fee for telehealth services furnished from Oct. 1, 2001, through Dec. 31, 2002, at $20. For telehealth services furnished on or after Jan. 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare economic index (MEI) as defined in section 1842(i)(3) of the Act. The MEI increase for 2016 is 1.1 percent. Therefore, for CY16, the payment amount for HCPCS code Q3014 (telehealth originating site facility fee) is 80 percent of the lesser of the actual charge or $25.10. The Medicare telehealth originating site facility fee and the MEI increase by the applicable time period is shown in Table 22 of the final rule.

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

Federal Register, pages 71065-71068

Final Update Summary: CMS will revise the requirements for which physicians or other practitioners can bill for incident-to services. Specifically, CMS will 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. CMS is not finalizing its proposal to delete the final 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. Instead, it will revise this sentence to reflect its policy that the physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) treating the patient more broadly. In addition to this revised sentence, it will add clarifying regulation text specifying that only the physician or other practitioner under whose supervision the incident-to service(s) are being provided is permitted to bill the Medicare program for the incident-to services. CMS is also finalizing the proposed change to the regulation with a clarifying modification. Specifically, it is amending the definition of the term, ''auxiliary personnel'' at §410.26(a)(1) that are permitted to provide ''incident-to'' services to exclude individuals who have been excluded from the Medicare program or have had their Medicare enrollment revoked. This 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 71080-71088

Final 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 prospective payment system (PPS) system in which they are paid based on the lesser of a national encounter-based rate or their total adjusted charges. The FQHC PPS rate is adjusted for geographic differences in the cost of services by the FQHC geographic adjustment factor. It is also increased by 34 percent when a FQHC furnishes care to a patient that is new to the FQHC or to a beneficiary receiving an initial preventive physical examination or an annual wellness visit. 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 (CCM) Services

The final rule will provide an additional payment for the costs of 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 for 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 of 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 generally not included in the RHC or FQHC payment.

Payment Methodology and Billing Requirements

The requirements CMS proposed 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 24 of the final rule (***Appendix 1*** of this document). Under the final rule, CMS will 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 will 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. 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 will 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 will be based on the PFS amount, but will 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 will waive the RHC and FQHC face-to-face requirements when CCM services are furnished to an RHC or FQHC patient. Coinsurance will be applied as applicable to FQHC claims, and coinsurance and deductibles will apply as applicable to RHC claims. RHCs and FQHCs will continue to be required to meet the RHC and FQHC conditions of participation and any additional RHC or FQHC payment requirements.

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 finalized the following requirements that must 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; and

- 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.

Scope of CCM Services in RHCs and FQHCs

All of the following scope-of-service requirements must 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; and
- 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.

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, under the final rule, 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 Dec.31 of the year preceding each CCM payment year to meet certain core technology capabilities. Also, applicable HIPAA standards would apply to electronic sharing of patient information. CMS finalizes the provisions pertaining to CCM Services for RHCs and FQHCs, as proposed, except to change ''30-day period'' to ''calendar month'' wherever it was used in the proposed rule. CMS made this change because under the Medicare PFS and the definition of CPT code 99490, CCM services are based on a calendar month, not a 30-day period.

Physician Quality Reporting System (PQRS)

Federal Register, pages 71135-71260

Final Update Summary: This section contains the final requirements for the PQRS. These requirements primarily focus on CMS's proposals related to the 2018 PQRS payment adjustment, which will be based on an eligible professionals (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). The proposals related to the 2018 PQRS payment adjustment were similar to the requirements CMS previously established for the 2017 PQRS payment adjustment. CMS notes that it received comments in previous years, as well as during the comment period for the proposed rule, requesting that it not make any major changes to the requirements for PQRS, and it believes that the final requirements address these commenters' desire for stable requirements.

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 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 will not

finalize its proposal to require the reporting of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for the PQRS survey for groups of 25–99 EPs who register to participate in the PQRS group practice reporting option (GPRO) and select the GPRO web interface as the reporting mechanism. CMS is, however, finalizing this proposal with respect to group practices of 100 or more EPs. Thus, it requires that, for the reporting periods occurring in 2016, all group practices of 100 or more EPs that register to participate in the GPRO select a CMS-certified survey vendor to report CAHPS for PQRS, regardless of the reporting mechanism the group practice uses. CMS notes that for reporting periods occurring in 2015, it currently requires all group practices of 100 or more EPs that register to participate in the GPRO select a CMS-certified survey vendor to report CAHPS for PQRS, regardless of the reporting mechanism the group practice uses.

In addition, it will continue to require the reporting of at least one applicable cross-cutting measure if an EP sees at least one Medicare patient in a face-to-face encounter and reports the PQRS quality measures via claims. Also, if the EP reports via qualified registry for the 12-month 2018 PQRS payment adjustment reporting period, an EP must report at least nine measures, covering at least three 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 one Medicare patient in a face-to-face encounter, it must report on at least one measure contained in the proposed cross-cutting measure set. For a group practice of two or more eligible professionals, for the 12-month 2018 PQRS payment adjustment reporting period, it must report at least 9 measures, covering at least three of the NQS domains. Of these measures, if it sees at least one Medicare patient in a face-to-face encounter, it would report on at least one measure in the cross-cutting measure set. 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 rule finalizes changes to the QCDR and qualified registry reporting mechanisms. No changes will be made to the other PQRS reporting mechanisms.

Changes to the Requirements for the QCDR

CMS clarifies issues related to QCDR self-nomination, as well as finalizes a change related to the requirements for an entity to become a QCDR. CMS will open the QCDR self-nomination period on Dec. 1 of the prior year. This will provide entities with an additional month to self-nominate. CMS notes, however, that the deadline for an entity becoming a QCDR to submit a self-nomination statement is still 5 p.m., Eastern Standard Time, on Jan. 31 of the year in which the clinical data registry seeks to be qualified. 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 Jan. 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, for an entity to become qualified for a given year, the entity must be in existence as of Jan. 1 the year

for which the entity 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 will allow QCDRs to attest during the data submission period using a web-based check box mechanism. CMS believes it is less burdensome for QCDRs to check a box acknowledging and attesting to the accuracy of the data they provide, rather than having to email a statement to CMS. As such, QCDRs will no longer be able to submit this attestation statement via email.

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 will 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 Jan. 31 of the year in which it intends to participate in the PQRS as a QCDR (that is, Jan. 31, 2016, to participate as a QCDR for the reporting periods occurring in 2016), as proposed. 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. CMS believes that it is important to implement these requirements in order for it to ensure the accuracy of the data collected by vendors. Therefore, a vendor will need to collect all necessary information by June 30, 2016.

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 finalized that QCDRs will also have the ability to submit quality measures data for group practices.

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 percent.

Tables 27 and 28 of the final rule (***Appendix 2*** of this document), reflects CMS's final criteria for satisfactory reporting or satisfactory participation in a QCDR for the 2018 PQRS payment adjustment.

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. CMS proposed that four new measures be added to the current PQRS crosscutting measure set. These measures, finalized as proposed, include:

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

- Falls: Plan of Care

A summary of the comments CMS received on these measures, its responses, as well as final decisions can be found in Table 29 of the final rule (***Appendix 3*** of this document). As such, for 2016, there will be a total of 23 crosscutting measures in PQRS. CMS notes that Table 30 (***Appendix 4*** of this document) contains additional measures that it proposed to include in the PQRS measure set for CY16 and beyond. CMS also indicates the PQRS reporting mechanism or mechanisms through which each measure could be submitted, as well as the Measure Applications Partnership (MAP) recommendations.

PQRS Measures Groups

CMS will 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 will 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 (Million 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. This measures group is also fully supported by the Million Hearts Initiative.

- ***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 will 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 34, 35, and 36 of the final rule, CMS provides the PQRS measure numbers for these measures.

Medicare Shared Savings Program

Federal Register, pages 71263-71273

Final Update Summary: CMS identified a few policies related to the quality measures and quality performance standard that it finalized in the rule. Specifically, it will 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.

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 these reviews, in the CY15 PFS final rule with comment period, CMS retired several measures that no longer aligned with updated clinical guidelines regarding cholesterol targets. As a result of retiring measures that did not align with updated clinical practice, it identified a gap in the Shared Savings Program measure set for measures that address treatment for patients at high risk of cardiovascular disease due to high cholesterol. CMS also identified a number of measure additions, deletions, and other revisions that it believes would be appropriate for the Shared Savings Program.

New Measures

CMS will add the following new measure to the Preventive Health domain of the Shared Savings Program, which will increase its current total number of measures from 33 to 34.

- **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; or
- 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.

As is its standard practice, CMS intends to make specifications for this measure available prior to the performance year in which it is applicable. CMS anticipates the final specifications for the Statin Therapy measure will be made public prior to the 2016 performance year. CMS tested the measure to assess the technical feasibility of the measure, as well as the extent to which measure scores are valid and reliable. This measure also reflects CMS's effort to adhere to current clinical guidelines. The statin therapy measure will be a single three-part measure scored as two points with an oversample of 750 beneficiaries. CMS is increasing the oversample from 616 to 750 beneficiaries for this measure, but the consecutive reporting requirement for measures reported through the CMS web interface will remain at 248 beneficiaries. The oversample size for this

measure is to account for reporting on the multiple denominators and to ensure a sufficient number of beneficiaries meet the measure denominators for reporting.

Although CMS proposed transitioning the measure to pay for performance in the third year of the agreement period, it is finalizing the measure as pay-for reporting for all reporting years, because a majority of commenters supported finalizing the measure as pay-for reporting only and because American College of Cardiology (ACC) and other experts are continuing to discuss non-statin therapy and reducing atherosclerotic cardiovascular disease risk. By finalizing the measure as pay-for reporting in all agreement years CMS hopes to provide ACOs, ACO participants, and ACO providers/suppliers with an opportunity to gain experience and become familiar with the ACC/AHA clinical guidance and multiple denominators of the measure. However, it agrees with commenters that stated support for measures of statin therapy and the importance of moving to pay for performance. CMS therefore intends to revisit this measure in future rulemaking to propose a timeline for phasing in pay for performance. As a result of adding this measure, the total points possible in the Preventive Health domain will increase from 16 points to 18 points, and the total measures in the Shared Savings Program measure set reported by ACOs will increase from 33 measures to 34 measures.

Data collection for the new measure will occur through the CMS web interface. Table 45 (***Appendix 5*** of this document) lists the measures for use in establishing quality performance standards that ACOs must meet for shared savings.

As a result of this measure addition, each of the four domains will 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 44 of the final 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 additional measure in the At-Risk Population domain. The total possible points for the Preventive Health domain will increase from 16 points to 18 points.

Policy for Measures No Longer Aligning With Clinical Guidelines, High Quality Care or Outdated Measure May Cause Patient Harm

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 will 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. CMS believes that maintaining or reverting

a measure to pay-for reporting will ensure ACOs will not be scored on their performance on the measure while CMS and the measure steward assess the measure specifications. CMS may propose to retire such a measure in the next rulemaking cycle, which will offer the public an opportunity to comment, and will put ACOs on sufficient notice about the retirement of the measure. CMS appreciated the comments it received suggesting immediate suspension, will explore this option further, and may consider proposing such an approach in the future. This change will also give the agency the flexibility 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.

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 primary care physicians (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 CMS did not propose any changes to the current measure, it requested comments 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. CMS will use the feedback as it determines how the measure could be updated and expanded to further incentivize and reward providers for using and adopting more advanced health IT. It will make any modifications necessary to permit the evolution of the measure through future rulemaking.

Assignment of Beneficiaries Based on Certain Evaluation and Management Services in SNFs

CMS finalized 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 comments 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 who would not otherwise be aligned to the ACO, and with whom the ACO has no clinical contact after their SNF stay. Therefore, CMS will 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 believes that excluding these services furnished in SNFs from the definition of primary care services will complement its goal of assigning beneficiaries to an ACO based on their utilization of primary care services. CMS also finalizes its proposal to make a conforming change to the definition of primary care services by indicating that the current definition will be in use for the 2016 performance year, and to add a new definition of primary care services, which excludes services furnished in SNFs from the definition of primary care services effective starting with the 2017 performance year. To conform to the precedent set by the June 2015

Shared Savings Program final rule, it will adjust all benchmarks at the start of the first performance year in which the new assignment rules are applied so that the benchmark for an ACO reflects the use of the same assignment rules as would apply in the performance year.

Assignment of Beneficiaries to ACOs that Include Electing Teaching Amendment Hospitals
CMS will add HCPCS code G0463 for services furnished in an electing teaching amendment (ETA) hospital to the definition of primary care services to codify its current practice for performance year 2016 and subsequent performance years. CMS is also revising §425.402 by adding a new paragraph (d) providing that when considering services furnished by physicians in ETA hospitals in the assignment methodology, it will 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. CMS also finalizes its proposal to amend §425.102(a) 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.

CMS makes corrections to a technical and typographical error at §425.502(d)(2)(ii) appearing in the 2015 PFS final rule with comment period that were not subsequently reflected in the regulations text resulting in the Code of Federal Regulations (CFR) not being updated to reflect its final policies. CMS includes the previously finalized revisions to §425.502(d)(2)(ii) in the final rule as they were finalized in the 2015 PFS final rule with comment period.

Value-Based Payment Modifier and Physician Feedback Program

Federal Register, pages 71273-71300

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 nonphysician EPs who are solo practitioners.

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) based on the TIN's performance during the applicable performance period. 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 beginning in CY18, physicians and nonphysician EPs will be subject to the same VM policies established in earlier rulemakings and under subpart N. For example, nonphysician EPs will be subject to the same amount of payment at risk and quality-tiering policies as physicians. CMS finalized modifications to the regulations under subpart N accordingly. In that rule, CMS also 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 will 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.

Approach to Setting the VM Adjustment Based on PQRS Participation

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

In the CY16 MPFS final rule, CMS finalized the two-category approach for the CY18 VM based on participation in the PQRS by groups and solo practitioners. Category 1 will include groups that have at least 50 percent of the group's EPs meet the criteria to avoid the PQRS payment adjustment for CY17 as individuals. Category 1 will also include those groups that meet the criteria to avoid the PQRS payment adjustment for CY18 as a group practice participating in the PQRS GPRO, as finalized in Table 28 of the final rule (***Appendix 7*** of this document). Included in this category are also groups that have at least 50 percent of the group's EPs meet the criteria to avoid the PQRS payment adjustment for CY18 as individuals, as finalized in Table 27 of the final rule (***Appendix 8*** of this document). The 50 percent threshold must be met regardless of whether the group registers for a PQRS GPRO. If a group registers for a PQRS GPRO and meets the criteria to avoid the PQRS payment adjustment as a group, then the group-level quality data reported through the GPRO reporting mechanism would be taken into account for purposes of applying the CY18 VM.

Category 2 will include those groups and solo practitioners that are subject to the CY18 VM and do not fall within Category 1. For a group or solo practitioner subject to the CY18 VM to be included in Category 1, the criteria for satisfactory reporting (or the criteria for satisfactory participation in the case of solo practitioners, and the 50 percent option described above for groups) must be met during the reporting periods occurring in CY16 for the CY18 PQRS payment adjustment. CY16 will be the performance period for the VM adjustments that will apply during CY18.

2018 Value-Based Payment Modifier *(VBPM) Adjustment Based on 2016 PQRS Participation*

CMS will 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; or
- 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 will include EPs and groups participating in a Medicare Shared Savings Program ACO that do not successfully report quality measures data in Category 2.

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. CMS finalizes that it will apply the quality-tiering methodology to all groups and solo practitioners in Category 1 for the CY18 VM. As such, groups and solo practitioners will be subject to upward, neutral, or downward adjustments derived under the quality-tiering methodology (with the exception discussed in section III.M.4.b. of the final rule, that PAs, NPs, CNSs, and CRNAs in groups that consist of nonphysician EPs and PAs, NPs, CNSs, and CRNAs who are solo practitioners will be held harmless from downward adjustments under the quality-tiering methodology in CY18), with the following modifications:

- CMS is finalizing an increase to the minimum episode number requirement for the Medicare Spending per Beneficiary (MSPB) measure in the CY17 and 2018 payment adjustment periods to 125 episodes, for solo practitioners and for groups of all sizes, in section III.M.4.k of the final rule.

CMS will not include the all-cause hospital readmissions measure in the quality composite for solo practitioners and groups of two to nine EPs for the CY17 and 2018 payment adjustment periods. CMS believes that this final policy best addresses commenters' concerns with small sample sizes for solo practitioners and groups of two to nine EPs, while preserving the emphasis on provision of high quality efficient and effective care.

Application of the VM to Solo Practitioners and Groups with EPs Who Participate in the Pioneer ACO Model, the CPC Initiative, the Comprehensive ESRD Care Initiative, Oncology Care Model, and the Next Generation ACO Model

CMS received many comments on its proposals made in the CY15 PFS proposed rule to exempt the Pioneer ACO Model and CPC Initiative participants from the VM. As it noted in response to

comments in the CY15 final rule, a few commenters also suggested that the application of the VM to Innovation Center initiatives, including the Next Generation ACO Model, Oncology Care Model, and Comprehensive ESRD Care Initiative, should be waived under section 1115A of the Act. CMS agreed with the commenters that it would be appropriate to use the waiver authority with regard to the Pioneer ACO Model, the CPC Initiative, and other similar Innovation Center models, including the Next Generation ACO Model, the Oncology Care Model, and the Comprehensive ESRD Care Initiative, all as proposed without modification. However, the VM will apply to MSSP participants.

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 47 of the final rule) shows the final quality-tiering payment adjustment amounts for CY18 for physicians, PAs, NPs, CNSs, and CRNAs in groups with 10 or more EPs.

TABLE 47—FINAL CY 2018 VM AMOUNTS FOR THE QUALITY-TIERING APPROACH FOR PHYSICIANS, PAS, NPS, CNSS, AND CRNAS IN GROUPS OF PHYSICIANS 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 48 (below) of the final rule shows the final 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 48—FINAL CY 2018 VM AMOUNTS FOR THE QUALITY-TIERING APPROACH FOR PHYSICIANS, PAS, NPS, CNSS, AND CRNAS IN GROUPS OF PHYSICIANS 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 49 of the final rule) shows the final 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 49—FINAL 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 final approach will reward groups and solo practitioners that provide high-quality/low-cost care. CMS will use CY16 as the performance period for the VM payment adjustments that will apply during CY18.

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

CMS will waive application of the VM for the Pioneer ACO Model; CPC Initiative; and other similar Innovation Center models, including the Next Generation ACO Model, the Oncology Care Model, and the Comprehensive ESRD Care Initiative, all as proposed without modification. 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. CMS proposed 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

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

CMS will continue calculating these three additional quality outcome measures that are included in the quality composite score. For the CY18 VM, CMS will 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 27 and 28 of the final rule with comment period. Additionally, CMS is finalizing its proposal to use all of the quality measures that are available to be reported under these various PQRS reporting mechanisms to calculate a group's 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. These quality measures are described in Tables 29 through 42 of the final rule with comment period.

Cost Composite

Beginning with the CY16 payment adjustment period, a group or solo practitioner subject to the VM will receive a cost composite score that is classified as average under the quality-tiering methodology if the group or solo practitioner does not have at least one cost measure with at least 20 cases. CMS observed that groups that do not provide primary care services are not

attributed beneficiaries or are attributed fewer than 20 beneficiaries, and, thus, it is unable to calculate reliable cost measures for those groups of physicians. A group or solo practitioner subject to the VM will receive a cost composite score that is classified as average under the quality-tiering methodology if the group or solo practitioner does not have at least one cost measure that meets the minimum number of cases required for the measure to be included in the calculation of the cost composite. Consequently, to the extent a group's or solo practitioner's cost composite is classified as high, average, or low, the group's or solo practitioner's VM will reflect that classification. This policy is consistent with the policy CMS finalized in the CY15 PFS final rule with comment period that, beginning with the CY16 payment adjustment period, a group or solo practitioner subject to the VM will receive a cost composite score that is classified as average under the quality-tiering methodology if the group or solo practitioner does not have at least one cost measure with at least 20 cases and thus a reliable cost composite cannot be calculated for the group or solo practitioner.

Beginning with the CY17 payment adjustment period, CMS is finalizing its proposal to increase the minimum number of episodes for inclusion of the MSPB measure in the cost composite to 125 episodes. Therefore, it is also finalizing its proposed revisions to §414.1265(b) to indicate that a group or solo practitioner subject to the VM will receive a cost composite score that is classified as average under the quality-tiering methodology if the group or solo practitioner does not have at least one cost measure that meets the minimum number of cases required for the measure to be included in the calculation of the cost composite. Consequently, to the extent a group's or solo practitioner's quality composite is classified as high, average, or low, the group's or solo practitioner's VM will reflect that classification.

Medicare Spending per Beneficiary Measure for VBPM Cost Composite

An episode minimum of 125 episodes will be required for the MSPB measure, beginning with the CY17 payment adjustment period and CY15 performance period, meaning a TIN will have to have at least 125 MSPB episodes for the measure to be included in the cost composite. CMS conducted a more granular reliability analysis, based on which it determined a minimum of 125 episodes are required in order for this measure to meet its average reliability threshold of 0.4 for solo practitioners and groups of two to nine EPs. Based on this new analysis, CMS believes that a minimum of 125 episodes is preferable to the reliability associated with the other minimum numbers of episodes suggested by some commenters.

A group or solo practitioner subject to the VM will receive a cost composite score that is classified as "average quality" 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. Consequently, to the extent a group's or solo practitioner's quality composite is classified as high, average, or low, the group's or solo practitioner's VM will reflect that classification.

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. CMS will not include the all-cause hospital readmissions measure in the quality composite for solo practitioners and groups of two to nine EPs for the CY17 and 2018 payment adjustment periods.

The quality measurement component of the VM includes three outcome measures that CMS calculates from FFS Medicare claims:

- Two composite measures of hospital admissions for ambulatory care-sensitive conditions
  - acute conditions
  - chronic conditions
- One measure of 30-day all-cause hospital readmissions

The VM website contains the measure information forms for the three outcome measures that are included in the quality composite of the VM. https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeedbackprogram/valuebasedpaymentmodifier.html.

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 will 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 will exclude eCQM measures from the overall benchmark for a given measure and create separate eCQM benchmarks, based on the CMS eMeasure ID, beginning with the CY16 performance period for which the eCQM benchmarks will be calculated based on CY15 performance data.

Additional Upward Payment Adjustment to High Quality Participant Shared Savings Program ACOs
Beginning in the CY17 payment adjustment period, CMS will 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 will 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. CMS finalizes the continuation of the process for accepting requests from groups and solo practitioners to correct certain errors made by CMS or a third-party vendor (for example, PQRS-qualified registry).

Physician Feedback Program
In fall 2015, CMS expanded the Physician Feedback Program by making QRURs, containing data on cost and quality performance during calendar year 2014, available to all solo practitioner EPs and groups of EPs of all sizes, as identified by TIN, including nonphysician EP solo practitioners and groups comprised of nonphysician EPs. It made 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 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 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 it invited comment on which aspects of the QRUR reports have been most useful and how it can improve access to and usability of performance reports. Commenters expressed concerns about timeliness of reports; the accessibility of the reports; the complexity of the reports, and the outreach regarding the VM program. In response to previous comments about the timeliness of reports, this year CMS disseminated the Mid-Year QRURs, the Annual QRURs, and the Supplemental QRURs. It has also made strides to simplify the outreach around how to access the reports. Further, it has continued to engage its stakeholders and seek input on how best to refine the reports. CMS will continue to engage the stakeholder community to determine how best to educate about value-based payment programs.

Electronic Health Record Incentive Program

Federal Register, pages 71261-71262

CMS revises 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 certified EHR technology (CEHRT) before 2018, CMS will 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 will require technology to be certified to the Quality Reporting Document Architecture (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 will also 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 will require technology to be certified to the QRDA Category I and III standards also. These revisions will apply for EPs, eligible hospitals, and critical access hospitals (CAHs). CMS finalizes 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 71300-71341

The final rule updates the physician self-referral regulations to accommodate delivery and payment system reform, reduce burden, and facilitate compliance. CMS learned from stakeholder inquiries, review of relevant literature, and self-disclosures submitted to the Medicare self-referral disclosure protocol that additional clarification of certain provisions of the physician self-referral law would be helpful. In addition to clarifying the regulations, CMS is interested in expanding access to needed health care services. In keeping with those goals, the

final rule expands the regulations to establish two new exceptions and clarifies certain regulatory terminology and requirements.

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 provides 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 finalizes its proposal that a public website for the hospital does not include, by way of example: social media websites; electronic patient payment portals; electronic patient care portals; and electronic health information exchanges. CMS defines 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 finalizes 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, as well as its examples of language that would satisfy that standard as specified in the proposed rule. CMS notes that its goal in proposing the examples of sufficient disclosure statements was to articulate a common sense understanding of what types of statements would satisfy the requirements.

Bona Fide Investment Level

After consideration of the comments, CMS is amending its existing regulations to specify that, for the purposes of §411.362 (including for the purposes of determining the baseline bona fide investment level and the bona fide investment level thereafter), the ownership or investment interests held by both referring and non-referring physicians are included. CMS is establishing a definition of ownership or investment interest solely for the purposes of §411.362 that would apply to all types of owners or investors, regardless of their status as referring or non-referring physicians. Specifically, it defines ‘‘ownership or investment interest’’ as a direct or indirect ownership or investment interest in a hospital. Under the final rule, a direct ownership or investment interest in a hospital exists if the ownership or investment interest in the hospital is held without any intervening persons or entities between the hospital and the owner or investor. An indirect ownership or investment interest in a hospital exists if:

1. Between the owner or investor and the hospital, there exists an unbroken chain of any number (but no fewer than one) of persons or entities having ownership or investment interests; and

2. The hospital has actual knowledge of, or acts in reckless disregard or deliberate ignorance of, the fact that the owner or investor has some ownership or investment interest (through any number of intermediary ownership or investment interests) in the hospital.

CMS will require that the baseline bona fide investment level and the bona fide investment level include direct and indirect ownership and investment interests held by a physician if he or she satisfies this 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 the purposes of its regulatory definition of ownership or investment interest). The term ‘‘physician’’

would continue to have the meaning set forth in §411.351; that is, an individual who meets the definition of ''physician'' set forth in section 1861(r) of the Social Security Act. CMS is delaying the effective date of this revision for one year from the effective date of the final rule to Jan. 1, 2017, to allow physician-owned hospitals to have sufficient time to come into compliance with the revised policy.

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 proposed rule, CMS proposed to revise several definitions in its regulations to improve clarity and ensure proper application of its policies. CMS finalizes the following revised definitions as proposed, without additional modification.

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'' is defined as any arrangement involving any ''remuneration'' between a physician (and an immediate family member of such physician) and an entity. CMS revises 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 a physician's use of a hospital's resources (for example, examination rooms, nursing personnel, and supplies) when treating hospital patients will 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.

Although it did not propose regulatory revisions, CMS noted its concern about potential confusion regarding whether remuneration is conferred by a hospital to a physician when both facility and professional services are provided to patients in a hospital-based department. CMS received several written inquiries asking whether certain so-called ''split bill'' arrangements between physicians and DHS entities involve remuneration between the parties that gives rise to a compensation arrangement for the purposes of the physician self-referral law. CMS does not believe that this arrangement involves remuneration between the parties, because the physician and the DHS entity do not provide items, services, or other benefits to one another. CMS's clarification regarding split bill arrangements and remuneration applied only to the use of a hospital's space, items, and equipment. Following its review of the comments received, CMS is confirming its existing policy that a physician's use of a hospital's resources (for example, examination rooms, nursing personnel, and supplies) when treating hospital patients does not constitute remuneration under the physician self- referral law, when the hospital bills the appropriate payer for the resources and services it provides (including the examination room and other facility services, nursing and other personnel, and supplies), and the physician bills the payer for his or her professional fees only.

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 clarifies 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. For such purposes, CMS does not consider employees and independent contractors to be parties to a physician organization's arrangements unless they voluntarily stand in the shoes of the physician organization. Guidance regarding physicians who stand in the shoes of their physician organizations may be found on the CMS website at http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/FAQs.html.

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 inpatient prospective payment system (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 will modify the current regulation to allow parties 90 days to obtain the required signatures, regardless of whether the failure to obtain the signature(s) was inadvertent. Thus, CMS is finalizing its proposal to remove the distinction between inadvertent and not inadvertent failure to obtain a signature at § 411.353(g). The regulation, as finalized, continues to limit the use of §411.353(g) by an entity to once every three years for a particular physician.

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

1. *Timeshare Arrangements*:
   CMS continues to believe that timeshare arrangements may serve to ensure adequate access to needed health care services. CMS finalizes the exception for timeshare arrangements at §411.357(y) with the following modifications:

   - Regardless of which party grants and which party receives permission to use the premises, equipment, personnel, items, supplies, and services of the other party, a timeshare arrangement must be between a physician (or the physician organization) in whose shoes the physician stands and a:
     - Hospital; or
     - Physician organization of which the physician is not an owner, employee, or contractor;
   - Equipment included under the timeshare arrangement may be in the same building (as defined at § 411.351) as the office suite where E/M services are furnished; and
   - All locations under the timeshare arrangement, including the premises where E/M services are furnished and the premises where DHS are furnished, must be used on identical schedules.

   In addition, the exception as finalized protects only those arrangements that grant a right or permission to use the premises, equipment, personnel, items, supplies, or services of

another person or entity without establishing a possessory leasehold interest (akin to a lease) in the medical office space that constitutes the premises. CMS believes that the other safeguards in the exception finalized here are necessary at this time to protect against program or patient abuse.

2. *Assistance to Compensate Non-physician Practitioners*
After consideration of the comments it received regarding the exception for assistance from a hospital, FQHC, or RHC to a physician to compensate a non-physician practitioner (NPP), CMS finalizes its proposed exception at §411.357(x) with the following modifications:

    - It is including in the definition of ''non-physician practitioner,'' clinical social workers, and clinical psychologists;
    - It is expanding the type of services that may be furnished by the NPP to patients of the physician's practice to include mental health care services;
    - It is including a requirement that the NPP furnish substantially all primary care services or mental health services (rather than ''only'' such services) to patients of the physician's practice;
    - It is not limiting the type of compensation arrangement between the physician (or physician organization in whose shoes the physician stands) and the NPP, but will require that the contractual relationship for which assistance is provided by a hospital, FQHC, or RHC is directly between the physician (or a physician organization in whose shoes the physician stands under § 411.354(c)) and the NPP;
    - It is establishing a bright-line approach to the amount of permissible remuneration from the hospital, FQHC, or RHC to the physician, limiting it to 50 percent of the actual aggregate compensation, signing bonus, and benefits paid to the NPP;
    - It is finalizing a limit on the frequency with which a hospital, FQHC, or RHC may provide assistance to the same physician and setting the limitation at no more than once every three years, with an exception if the NPP does not remain with the physician's practice for at least one year; and
    - It is shortening the period of time that the NPP must not have practiced in the geographic area served by the hospital, FQHC, or RHC providing the assistance from three years to one year.

Potential Expansion of the Comprehensive Primary Care (CPC) Initiative

Federal Register, pages 71262-71263

In the CPC initiative, CMS is collaborating with commercial payers and state Medicaid agencies to test a payment and service delivery model that includes the payment of monthly non-visit based per beneficiary per month care management fees and shared savings opportunities. 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 section1115A

(b) of the Act. Given that further evaluation is needed to determine its impact on both Medicare cost and quality of care, CMS did not propose an expansion of the CPC initiative in the CY16 PFS proposed rule, but requested 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 practices 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.

In response to its request, CMS received over 90 timely and informative public comments suggesting matters to consider in a potential future expansion of the CPC initiative, including engagement of EHR vendors, coaching on leadership and change management, documentation, and beneficiary cost-sharing. These comments, submitted by a variety of stakeholders, broadly supported CPC expansion. CMS appreciates the commenters' views and recommendations, and will consider the comments if the CPC initiative is expanded in the future through rulemaking.

More Information

The final rule was published in the Nov. 16, 2015, *Federal Register*. Additional information regarding the Medicare Physician Fee Schedule is available on the CMS website.

Appendix 1: Final Requirements for RHCs and FQHCs to Receive Payment for CCM Services

TABLE 24—SUMMARY OF 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 visit.	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 appointments.	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 medications.	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 – PQRS Reporting Requirements

TABLE 27—SUMMARY OF 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.

TABLE 28—SUMMARY OF 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).	25–99 EPs; 100+ EPs (if *CAHPS for PQRS does not apply).	Individual GPRO Measures in the Web Interface.	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.

Appendix 2 – PQRS Reporting Requirements - Continued

TABLE 28—SUMMARY OF REQUIREMENTS FOR THE 2018 PQRS PAYMENT ADJUSTMENT: GROUP PRACTICE REPORTING CRITERIA FOR SATISFACTORY REPORTING OF QUALITY MEASURES DATA VIA THE GPRO—Continued

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1–Dec 31, 2016).	25–99 EPs that elect CAHPS for PQRS; 100+ EPs (if CAHPS for PQRS applies).	Individual GPRO Measures in the Web Interface + CAHPS for PQRS.	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 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. Please note that, if the CAHPS for PQRS survey is applicable to a group practice who reports quality measures via the Web Interface, the group practice must administer the CAHPS for PQRS survey in addition to reporting the Web Interface measures.
12-month (Jan 1–Dec 31, 2016).	2–99 EPs; 100+ EPs (if CAHPS for PQRS does not apply).	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.
12-month (Jan 1–Dec 31, 2016).	2–99 EPs that elect CAHPS for PQRS; 100+ EPs (if CAHPS for PQRS applies).	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).	2–99 EPs; 100+ EPs (if CAHPS for PQRS does not apply).	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).	2–99 EPs that elect CAHPS for PQRS; 100+ EPs (if CAHPS for PQRS applies).	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.

Appendix 2 – PQRS Reporting Requirements - Continued

TABLE 28—SUMMARY OF REQUIREMENTS FOR THE 2018 PQRS PAYMENT ADJUSTMENT: GROUP PRACTICE REPORTING CRITERIA FOR SATISFACTORY REPORTING OF QUALITY MEASURES DATA VIA THE GPRO—Continued

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 3: Individual Quality Cross-Cutting Measures for the PQRS Beginning in 2016

TABLE 29: Individual Quality Cross-Cutting Measures for the PQRS to be Available for Satisfactory Reporting via Claims, Registry, and EHR beginning in 2016

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description[1]	Measure Steward	Other Quality Reporting Programs
Measures Finalized as Proposed					
2152/ 431	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. This measure was 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. While several commenters agreed this measure was appropriately classified as cross-cutting, one commentor suggested this measure be delayed for implementation as cross-cutting to allow providers time to standardize documentation processes. CMS continues to believe this is a broadly applicable measure reportable by several provider types and should be relatively easy for providers to document. For this reason, CMS is finalizing its proposal to make this measure reportable as a cross-cutting measure for 2016 PQRS.	American Medical Association – Physician Consortium for Performance Improvement	
2372/ 112	125v4	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. 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). This measure was 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. Several commenters agreed this measure was appropriately classified as cross-cutting. One commenter suggested that designating this measure as cross-cutting "may be viewed as an endorsement of a reduction in the frequency of screening and may compromise patient care". CMS believes that designating a measure as cross-cutting would not impact patient access to appropriate care. CMS believes that providers should adhere to clinical guidelines and not treat patients based on quality measures. CMS continues to believe this is a broadly applicable measure reportable by a number of providers. For these reasons, CMS is finalizing its proposal to include this measure as cross-cutting beginning in 2016 for PQRS.	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. 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.	National Committee for Quality Assurance/ American Medical Association – Physician Consortium	

Appendix 3: Individual Quality Cross-Cutting Measures for the PQRS Beginning in 2016 - Continued

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description[¥]	Measure Steward	Other Quality Reporting Programs
			This measure was proposed as a cross-cutting measure for PQRS for CY 2016 PFS as it is applicable to a variety of physician specialties and should be integrated into the standard of care for providers who serve patients with a history of falls. Commenters agreed this measure was appropriately classified as cross-cutting. For this reason, CMS is finalizing its proposal to make this measure reportable as a cross-cutting measure for 2016 PQRS.	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. 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. This measure was proposed as a cross-cutting measure for PQRS for CY 2016 as it is applicable to a variety of physician specialties and should be integrated into the standard of care for providers who serve patients with a history of falls. Commenters agreed this measure was appropriately classified as cross-cutting. For this reason, CMS is finalizing its proposal to make this measure reportable as a cross-cutting measure for 2016 PQRS.	National Committee for Quality Assurance/ American Medical Association – Physician Consortium for Performance Improvement	

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

Appendix 4: New Quality Measures and Those Included in PQRS Measures Groups Beginning in 2016

TABLE 30: New Individual Quality Measures and those Included in Measures Groups for the PQRS to be Available for Satisfactory Reporting Beginning in 2016

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description [1] (Includes Numerator, Denominator, Exclusion Criteria, and Exceptions Information)	2015 MAP Recommendation and NPRM Rationale	Public Comments and Responses	Measure Steward	Claims	Certified Survey Vendor (CSV)	Registry	EHR	GPRO Web Interface	Measures Groups
Measures Finalized as Proposed or with Modifications												
N/A/ 403	N/A	Person and Caregiver-Centered Experience and Outcomes	**Adult Kidney Disease: Referral to Hospice:** Percentage of patients aged 18 years and older with a diagnosis of end-stage renal disease (ESRD) who withdraw from hemodialysis or peritoneal dialysis who are referred to hospice care.	Encourage Continued Development Although this measure is not NQF-endorsed, we are exercising our exception authority under section 1848(k)(2)(C)(ii) of the Act to propose this measure because a feasible and practical measure has not been endorsed by the NQF that has been submitted to the measures application partnership. This measure supports interdisciplinary communication between EPs providing palliative care to Medicare patients. This measure fills a clinical gap in the program, as it addresses palliative care.	Several commenters supported the inclusion of this measure in PQRS. However, one commenter was concerned the nephrologist will have to engage palliative care providers prior to the decision to withdraw from dialysis and that not all patients who are referred to hospice choose to immediately withdraw from dialysis. CMS continues to believe this is a valuable measure that fills a clinical gap in the program. As indicated in the measure specification, this measure is assessing if a referral to hospice is made for those patients who withdraw from dialysis and as such CMS does not believe palliative care must be engaged prior to this decision. For these reasons, CMS is finalizing this measure for reporting in 2016 PQRS.	Renal Physicians Association/ American Medical Association – Physician Consortium for Performance Improvement			X			
N/A/ 439	N/A	Efficiency and Cost Reduction	**Age Appropriate Screening Colonoscopy:** The percentage of patients greater than 85 years of age who received a screening colonoscopy from January 1 to December 31.	Encourage Continued Development Although this measure is not NQF-endorsed, we are exercising our exception authority under section 1848(k)(2)(C)(ii) of the Act to	The title of this measure has been updated since appearing in the CY 2016 PFS proposed rule (originally entitled "Unnecessary Screening Colonoscopy in Older Adults" in Table 23 at 80 FR 41832 through	American Gastroenterological Association/ American Society for Gastrointestinal Endoscopy/ American College of Gastroenterology			X			

Appendix 4: New Quality Measures and Those Included in PQRS Measures Groups Beginning in 2016 - Continued

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description [3] (Includes Numerator, Denominator, Exclusion Criteria, and Exceptions Information)	2015 MAP Recommendation and NPRM Rationale	Public Comments and Responses	Measure Steward	Claims	Certified Survey Vendor (CSV)	Registry	EHR	GPRO Web Interface	Measures Groups
				propose this measure because a feasible and practical measure has not been endorsed by the NQF that has been submitted to the measures application partnership. This measure fills a clinical concept gap in the PQRS, as it addresses the overuse of colonoscopy which further addresses efficiency and cost aspects of health care.	41857) and conforms to the measure steward's most current measure specification. Commenters supported the inclusion of this measure in PQRS and urged CMS to encourage measure developers to obtain NQF-endorsement as soon as possible. CMS is exercising our exception authority under section 1848(k)(2)(C)(ii) of the Act to finalize this measure because a feasible and practical measure has not been endorsed by the NQF for a specified topic, as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. Another commenter was concerned with CMS not proposing this measure for claims reporting option, noting that not all eligible professionals have the resources to implement registry reporting. CMS appreciates the commenter's concerns and believes that exclusion of the claims-based reporting option will not negatively impact a significant number of providers reporting this measure. For these reasons, CMS is finalizing this measure for registry reporting in 2016 PQRS.							

Appendix 4: New Quality Measures and Those Included in PQRS Measures Groups Beginning in 2016 - Continued

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description [v] (Includes Numerator, Denominator, Exclusion Criteria, and Exceptions Information)	2015 MAP Recommendation and NPRM Rationale	Public Comments and Responses	Measure Steward	Claims	Certified Survey Vendor (CSV)	Registry	EHR	GPRO Web Interface	Measures Groups
N/A/ 404	N/A	Effective Clinical Care	**Anesthesiology Smoking Abstinence:** The percentage of current smokers who abstain from cigarettes prior to anesthesia on the day of elective surgery or procedure.	Encourage Continued Development Although this measure is not NQF-endorsed, we are exercising our exception authority under section 1848(k)(2)(C)(ii) of the Act to propose this measure because a feasible and practical measure has not been endorsed by the NQF that has been submitted to the measures application partnership. This measure clinically supports positive outcomes for patients undergoing anesthesia. This measure supports a gap in reporting for EPs who practice in anesthesia.	Several commenters were concerned with this measure proposed as registry only reporting option, noting that not all eligible professionals have the resources to implement registry reporting. CMS appreciates the commenters' concerns and believes this measure being reportable by registry only will not negatively impact a significant number of providers. It is CMS's goal to lower the data error rate and decrease provider burden. For these reasons, CMS is finalizing this measure for reporting in 2016 PQRS.	American Society of Anesthesiologists			X			

Appendix 5: Shared Savings Program Quality Measure Set

TABLE 45: Measures for Use in Establishing Quality Performance Standards that ACOS Must Meet for Shared Savings

Domain	ACO Measure #	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)		Adapted NQF #2510 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	CMS Web Interface	R	P	P

Appendix 5: Shared Savings Program Quality Measure Set – Continued

				NCQA				
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 CMS	CMS Web Interface	R	**R**	**R**
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 ACO - 41: Diabetes: Eye Exam		NQF #0059 NCQA (individual component)	CMS Web Interface	R	**P**	**P**
	ACO - 41			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 Vascu ar 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 44—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: Requirements For The 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria For Satisfactory Reporting via the GPRO

TABLE 28—SUMMARY OF 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).	25–99 EPs; 100+ EPs (if *CAHPS for PQRS does not apply).	Individual GPRO Measures in the Web Interface.	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).	25–99 EPs that elect CAHPS for PQRS; 100+ EPs (if CAHPS for PQRS applies).	Individual GPRO Measures in the Web Interface + CAHPS for PQRS.	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 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. Please note that, if the CAHPS for PQRS survey is applicable to a group practice who reports quality measures via the Web Interface, the group practice must administer the CAHPS for PQRS survey in addition to reporting the Web Interface measures.
12-month (Jan 1–Dec 31, 2016).	2–99 EPs; 100+ EPs (if CAHPS for PQRS does not apply).	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.
12-month (Jan 1–Dec 31, 2016).	2–99 EPs that elect CAHPS for PQRS; 100+ EPs (if CAHPS for PQRS applies).	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).	2–99 EPs; 100+ EPs (if CAHPS for PQRS does not apply).	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).	2–99 EPs that elect CAHPS for PQRS; 100+ EPs (if CAHPS for PQRS applies).	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.

Appendix 7: Requirements For The 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria for Satisfactory Reporting via the GPRO - Continued

TABLE 28—SUMMARY OF REQUIREMENTS FOR THE 2018 PQRS PAYMENT ADJUSTMENT: GROUP PRACTICE REPORTING CRITERIA FOR SATISFACTORY REPORTING OF QUALITY MEASURES DATA VIA THE GPRO—Continued

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: Requirements for 2018 PQRS Payment Adjustment: Individual Reporting Criteria for Satisfactory Reporting via Claims, Qualified Registry, and EHRs and Satisfactory Participation Criterion in QCDRs

TABLE 27—SUMMARY OF 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.