MLN Connects™

National Provider Call

CMS Proposals for Quality Reporting Programs under the 2015 Medicare Physician Fee Schedule Proposed Rule

July 24, 2014

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Agenda

- 2015 Medicare Physician Fee Schedule (MPFS) Proposed Rule
  - 2017 Payment Adjustments
  - Physician Quality Reporting System (PQRS)
  - EHR Incentive Program
  - Public Reporting
  - Value-Based Payment Modifier (VM)
  - Medicare Shared Savings Program
- Comments & Resources
- Question & Answer Session

CY 2017 Payment Adjustments

Program	Applicable to	Adjustment Amount	Based on PY
PQRS	All EPs (Medicare physicians, practitioners, therapists)	-2.0 percent of Medicare Physician Fee Schedule (MPFS)	2015
Medicare EHR Incentive Program	Medicare physicians (if not a meaningful user)	-3.0% of MPFS	2015
Value-based Modifier	All Medicare physicians and non-physician EPs in groups with 2+ EPs and solo practitioners	**Non-PQRS reporters: -4.0% of MPFS** (automatic VM downward adjustment) **Mandatory Quality-Tiering Calculation for 3 groups of PQRS reporters: +4.0% to -4.0x% of MPFS** **Groups with 2-9 Eligible Professionals (EPs) and solo practitioners:** Upward or neutral VM adjustment based on quality tiering **Groups with 10+ EPs:** Upward, neutral, or downward VM adjustment based on quality tiering Groups and solo practitioners are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25 percent of all beneficiary risk scores nationwide.	2015

PQRS

Overview of PQRS Changes

- This proposed rule addresses changes to the MPFS, and other Medicare Part B payment policies. 2017 payment adjustment is based on 2015 PQRS reporting. CMS proposes:

EPs in Critical Access Hospitals are able to participate in PQRS using ALL reporting mechanisms, including Claims.

CMS does not propose a change to claims or certified survey vendors reporting mechanism for PQRS at this time.

CMS seeks comment on whether to propose in future rulemaking to allow more frequent submissions of data, such as quarterly or year-round submissions, rather than annually.

Proposed PQRS Updates and Changes

Measures Added

- 28 Measures for Individual Reporting and to Measures Groups (4)
- Measures address all National Quality Standard (NQS) Domains
  - 6 Patient Safety
  - 8 Effective Clinical Care
  - 5 Patient and Caregiver-Centered Experience and Outcomes
  - 1 Efficiency and Cost Reduction
  - 5 Communication and Care Coordination
  - 3 Community/ Population Health

Removal From PQRS

- 73 Measures proposed to be removed
- Measures from Claims or Registry
- 38 Measures were part of a Measures Group (Back Pain, Periop Care, Cardiovascular Prevention, and Ischemic Vascular Disease)
- Removing from Measures Groups:
  - Periop Care
  - Back Pain
  - Cardiovascular PV Care
  - IVD
  - Sleep Apnea
  - COPD

Proposed Changes to the Measures

- Remove Claims-based only reporting options for new measures
- Remove Claims-based reporting option from measures groups
- Define a Measures Group as a subset of 6 or more PQRS measures that have a particular clinical condition or focus in common
- Propose 2 new Measures Groups available for PQRS reporting beginning in 2015:
  - Sinusitis
  - Otitis (AOE)

Reporting Through Qualified Registry

CMS proposes to:

Require an EP or group practice who sees at least 1 Medicare patient in a face-to-face encounter to report on at least 2 cross-cutting PQRS measures.

Add surgical procedures to the face-to-face encounter list along existing visit codes like general office visit codes, outpatient visits, and surgical procedures.

Require that qualified registries be able to report and transmit data on all 18 cross-cutting measures, in addition to collecting and transmitting the data for at least 9 measures covering at least 3 of the NQS domains.

Extend the deadline for qualified registries to submit quality measures data, including, but not limited to, calculations and results, to March 31 following the end of the applicable reporting period (for example, March 31, 2016, for reporting periods ending in 2015).

Direct EHR and EHR Data Submission Vendor (DSV) Products

For 2015 and beyond, CMS proposes to have the EP or group practice provide the CMS EHR Certification Number of the product used by the EP or group practice for direct EHRs and EHR data submission vendors.

Reporting Through a QCDR

Proposed criterion for the satisfactory participation for 2017 PQRS payment adjustment:

Report on 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 the measures, report on at least 3 outcome measures, OR if 3 outcome measures are not available, report on at least 2 outcome measures and at least 1 related to resource use, patient experience of care, or efficient/ appropriate use.

Group Practice Reporting Option (GPRO)

CMS proposes to:

- Modify the deadline for group practice registration to June 30th of the year in which the reporting period occurs.
- Change the measure-applicability analysis (MAV) process to check whether an eligible professional or a group practice should have reported on any of the proposed cross-cutting measures.
- Require group practices to report on at least 2 cross-cutting measures (if they see at least 1 Medicare patient in a face-to-face encounter).
- Make a group practice subject to MAV if it does not report 1 cross-cutting measure (if they have at least 1 eligible professional who sees at least 1 Medicare patient in a face-to-face encounter).

For more information on MAV, please visit http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html.

2015 Medicare Electronic Health Record (EHR) Incentive Program

Proposals Related to the EHR Incentive Program

Comprehensive Primary Care Initiative (CPCI) Reporting

- CPCI practice sites are required to report to CMS a subset of the Clinical Quality Measures (CQMs) that were selected in the EHR Incentive Program Stage 2 final rule for EPs to report under the EHR Incentive Program beginning in CY 2015
- Propose to relax the reporting of NQS domains from 3 to at least 2 NQS domains as CPCI practice sites must report at least 9 of 11 measures and may not have measures to cover 3 domains

Medicare Shared Savings Program

- CMS proposes that EPs participating in an accountable care organization (ACO) under the Shared Savings Program satisfy the CQM reporting component of meaningful use of the Medicare EHR Incentive Program when: (1) the EP extracts data from the EHR necessary for ACO to satisfy its GPRO quality reporting requirements, and (2) the ACO satisfactorily reports the ACO GPRO measures through a CMS web interface

Physician Compare

- CMS proposes that successful participation in the EHR Incentive Program based on 2015 data will be reflected on the Physician Compare website in 2016

Public Reporting

Proposals Related to Public Reporting

The 2015 MPFS proposed rule outlines further expansion of public reporting on Physician Compare.

Groups	Individuals

• All PQRS GPRO measures via the GPRO Web Interface, Registry, & Claims and for group-level measures ACOs
• Benchmarks (mirroring Shared Savings Program)
• Consumer Assessment of Healthcare Providers & Systems (CAHPS) for PQRS and CAHPS for ACOs
	• Twenty 2013 Individual-level PQRS measures
	• All 2015 Individual-level PQRS measures via Registry, EHR, & Claims
	• Benchmarks for PQRS
	• QCDRs Measures Data
	  • Individual or Aggregate
	  • PQRS or Non-PQRS

Value-Based Payment Modifier

Value-Based Payment Modifier Presentation Overview

- Provide background on the Value-based Payment Modifier (VM).
- Explain how CMS is proposing to complete the phase in of the VM in 2017 based on performance in 2015.
- Explain how the VM is aligned with the reporting requirements under the PQRS.
- Explain how the VM will apply to participants of the Shared Savings Program, the Pioneer ACO Model, and the CPC Initiative.
- Review the cost measures included in the VM.
- Describe the timeline of 2015 activities related to PQRS and the VM.

What is the VM?

The VM is a new per-claim adjustment under the MPFS that is applied to the Medicare paid amount at the group (Taxpayer Identification Number "TIN") level to physicians billing under the TIN.

VM provides for differential payment under the PFS based on the quality of care furnished compared to cost of that care.

CMS proposes to clarify that the VM would apply only to PFS services billed on an assignment-related basis and not to non-assigned services, to avoid any impact on beneficiary cost-sharing.

The VM is aligned with and is based on participation in PQRS.

For more information on the VM, please visit:

- www.cms.gov/physicianfeedbackprogram
- http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

Proposed VM Policies for 2017

- Performance Year is 2015
- Applies to physicians and non-physician EPs who are solo practitioners or in groups with 2+ EPs
- Quality tiering is mandatory:

Groups with 2-9 EPs and solo practitioners receive only the upward or neutral VM adjustment (no downward adjustment).

Groups with 10+ EPs can receive upward, neutral, or downward VM adjustment.

Groups and solo practitioners are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25 percent of all beneficiary risk scores nationwide.

Proposed VM Policies for 2017 (cont.)

Quality Measures

- Reporting through GPRO-Web Interface, Qualified PQRS Registry, EHR, or 50% of EPs reporting individually (same as 2016)
- Patient Experience Measures: CAHPS for PQRS
  - Optional for groups with 2-99 EPs
  - Required for all groups with 100+ EPs
- Outcome Measures: Same as 2015 (see Appendix Slide 46)
  - All Cause Readmission
  - Composite of Acute Prevention Quality Indicators (bacterial pneumonia, urinary tract infection, dehydration)
  - Composite of Chronic Prevention Quality Indicators (COPD, heart failure, diabetes)

Cost Measures

- Same as 2016 (see Appendix Slide 47)
- Total per capita costs measures (Parts A & B)
- Total per capita costs for beneficiaries with 4 chronic conditions:
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Coronary Artery Disease
  - Heart Failure
  - Diabetes
- Medicare Spending Per Beneficiary measure

Proposed VM Policies for 2017 (cont.)

Informal Review Process

For 2015 adjustment, submit request by Jan. 31 (seeking comment on end of February deadline).

For 2016 adjustment and beyond, submit by 30 days after Quality and Resource Use Report (QRUR) dissemination.

If CMS erred:

- For 2015 adjustment, reclassify as "Average Quality" for error in quality composite and recalculate cost composite
- For 2016 adjustment and beyond, Recalculate both Quality and Cost Composites

Proposed VM Policies for 2017 (cont.)

Payment at risk is -4.0%, with potential upward adjustment of up of +4.0x ('x' represents the upward payment adjustment factor)

Proposed CY 2017 VM Amounts

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%

* Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores

Attribution Proposals for CY 2017 Payment Adjustment

- CMS proposes to modify the two-step attribution process for 5 Total Per Capita Cost Measures and 3 Outcome Measures:
  - Propose to eliminate the "pre-step" that identified all beneficiaries who have had at least one primary care service rendered by a physician in the TIN
  - Two-step assignment process remains intact with the proposed modification:

First, assign beneficiaries who have had a plurality of primary care services (allowed charges) rendered by primary care physicians, nurse practitioners (NPs), physician assistants (PAs), or clinical nurse specialists (CNSs) in the TIN. (We are proposing to move NPs, PAs, and CNSs from Step 2 to Step 1.).

Second, for beneficiaries that remain unassigned, assign beneficiaries who have received a plurality of primary care services (allowed charges) rendered by non-primary care physicians in the TIN.

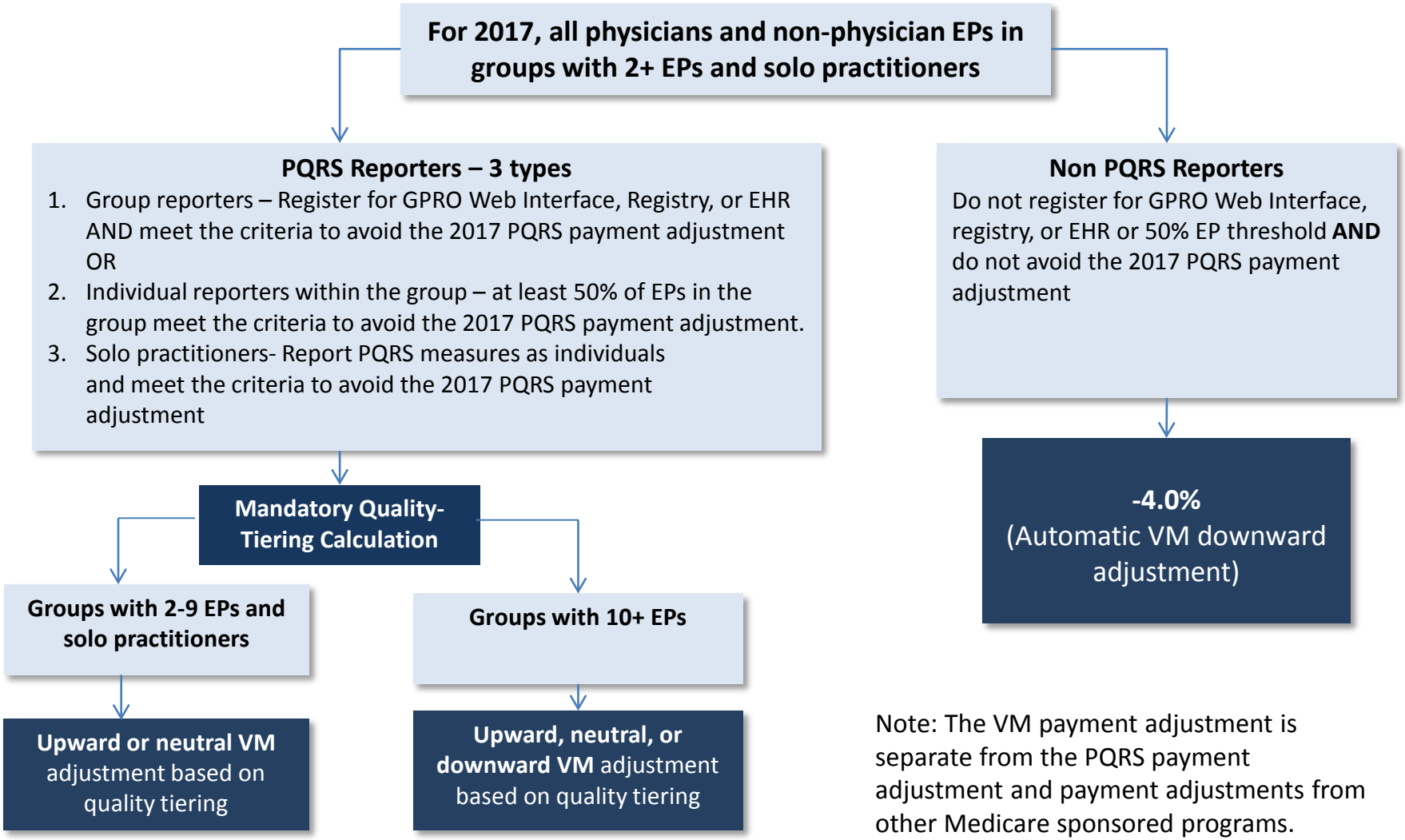
Proposal for Applying the VM to TINs participating in the Shared Savings Program

- Beginning CY 2017, CMS proposes to apply the VM to physicians and non-physician EPs in TINs that participate in the Shared Savings Program.
- In general, the cost composite for ACO participant TINs that participate in the Shared Savings Program during the payment adjustment period will be classified as "average cost," and their quality composite will be based on the ACO's quality data from the performance period using the quality-tiering methodology.
- Special rules apply for ACO participant TINs leaving/joining an ACO during the payment adjustment period.
- Refer to Slides 49-50 of the Appendix for a summary of the proposed policies for these TINs.

Proposal for Applying the VM to TINs participating in the Pioneer ACO Model, CPC Initiative, or Other Similar Innovation Center Models or CMS Initiatives

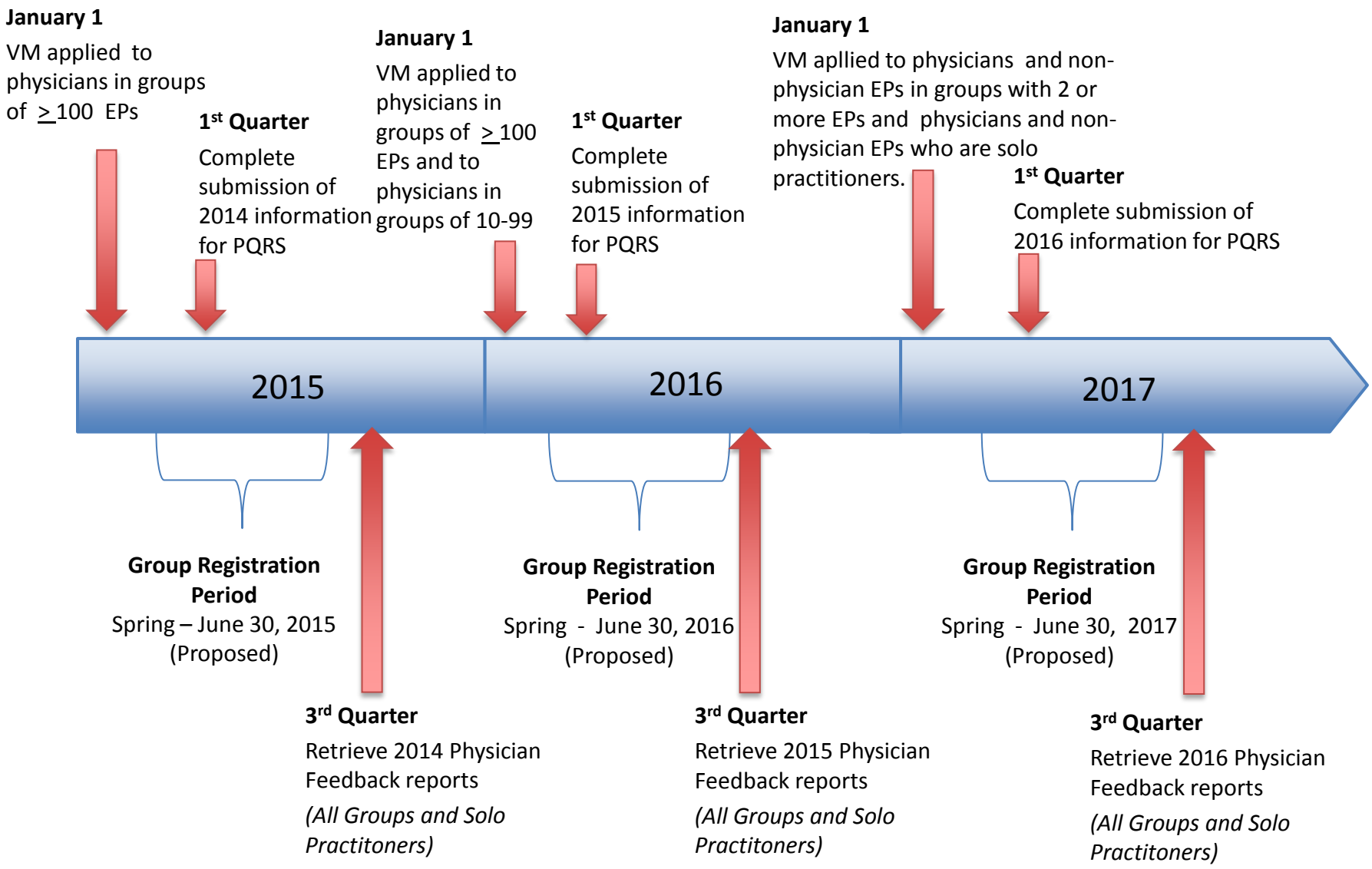
- Beginning CY 2017, CMS proposes to apply the VM to physicians and non-physician EPs in TINs that participate in the Pioneer ACO Model, CPC Initiative, or other similar innovation center models or CMS initiatives during the performance period.
- Refer to Slides 51-54 of the Appendix for a summary of the proposed policies for these TINs.

Value Modifier and the PQRS



Note: The VM payment adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.

Timeline for Value Modifier Phase In



What Should a Physician Group or Solo Practitioner Prepare To Do in 2015?

Actively participate in PQRS

- Group reporting
  - If group reporting, be prepared to register between Spring 2015 – June 30, 2015 (proposed)
- Individual Reporting – No registration necessary

Decide which PQRS measures to report and understand the measure specifications.

Obtain your Quality and Resource Use Report – available late summer of 2015.

Medicare Shared Savings Program

Overview of Medicare Shared Savings Program

- ACOs create incentives for health care providers to work together voluntarily to coordinate care and improve quality for their patient population.
- Individual providers and suppliers continue to bill and receive Medicare Fee-for-Service (FFS) payments as usual.
- CMS assesses ACO performance yearly on quality performance and against a financial benchmark to determine shared savings.

Overview of Medicare Shared Savings Program (cont.)

- Meeting the program's requirements for quality reporting and performance through the ACO GPRO has consequences for eligible professionals participating in ACOs:
  - PQRS
  - EHR Incentive Program
  - Value-based Payment Modifier

Shared Savings Program Regulatory Updates

Quality Measures:

- Update the quality reporting standard to:
  - Incorporate more claims based outcome measures that focus on post acute and chronic conditions
  - Remove redundant measures
  - Remove clinically outdated measures
  - Align with PQRS, VBM, and EHR Incentive Program measures
- Seeking comment on future quality measures.

Shared Savings Program Regulatory Updates (cont.)

Quality Assessment and Scoring:

- Revise the quality scoring strategy to recognize and reward ACOs that make year-to-year improvements in quality performance scores in each domain.
- Further modify the benchmarking methodology to take into account "topped out" measures.
- Assess the quality of ACOs in subsequent agreement periods based on the standard that would apply to the third year of the previous agreement period.

Shared Savings Program Regulatory Updates (cont.)

Alignment with other CMS quality reporting initiatives:

- Continue to align with the PQRS, including reducing the number of measures and the required sample size to be reported on using the ACO GPRO WI.
- Permit EPs to satisfy the eCQM portion of the EHR Incentive Program requirements if the EP extracts data necessary for the ACO to satisfy the quality reporting requirements from certified EHR technology, and the ACO satisfactorily reports quality measures.
- Seek comment on how to implement EHR-based reporting of quality measures.

Comments & Resources

How to Submit Comments on Proposals to the CY 2015 PFS Proposed Rule

Electronically	Mail	Hand or Courier

• You may submit electronic comments on this regulation to http://www.regulations.gov. Follow the instructions for "submitting a comment."	• You may regularly mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1612-P, P.O. Box 8013, Baltimore, MD 21244-8013. Please allow sufficient time for mailed comments to be received before the close of the comment period.
	• By express or overnight mail to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1612-P, Mail Stop C4-26-05, Baltimore, MD 21244-1850.
		• You may deliver your written comments before the close of the comment period to either of the following addresses:
		  • For delivery in Washington, DC -- CMS-1590-P, Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.
		  • For delivery in Baltimore, MD -- Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Resources

- **CMS PQRS Website**
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS
- **PFS Federal Regulation Notices**
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html
- **Medicare and Medicaid EHR Incentive Programs**
  http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms
- **Medicare Shared Savings Program**
  http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/ Quality_Measures_Standards.html
- **CMS Value-based Payment Modifier (VM) Website**
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ PhysicianFeedback Program/ValueBasedPaymentModifier.html
- **Physician Compare**
  http://www.medicare.gov/physiciancompare/search.html
- **Frequently Asked Questions (FAQs)**
  https://questions.cms.gov/
- **MLN Connects™ Provider eNews**
  http://cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Index.html
- **PQRS Listserv**
  https://public-dc2.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_520

Where to Call for Help

- **QualityNet Help Desk:**

  866-288-8912 (TTY 877-715-6222)

  7:00 a.m.–7:00 p.m. CST M-F or **qnetsupport@hcqis.org**
  You will be asked to provide basic information such as name, practice, address, phone, and e-mail

- **Provider Contact Center:**

  Questions on status of 2013 PQRS/eRx Incentive Program incentive payment (during distribution timeframe)

  See *Contact Center Directory* at
  http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

- **EHR Incentive Program Information Center:**

  888-734-6433 (TTY 888-734-6563)

- **ACO Help Desk via the CMS Information Center:**
  888-734-6433 Option 2 or cmsaco@cms.hhs.gov

- **VM Help Desk:**
  888-734-6433 Option 3 or pvhelpdesk@cms.hhs.gov

Question & Answer Session

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- This call has been approved by CMS for continuing medical education (CME) and continuing education unit (CEU) credit.

- To obtain continuing education credit
  - Review CE Activity Information & Instructions for specific details: http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/TC-L07242014-Marketing-Materials.pdf

Thank You

- For more information about the MLN Connects™ National Provider Call Program, please visit http://cms.gov/Outreach-and-Education/Outreach/NPC/index.html
- For more information about the Medicare Learning Network® (MLN), please visit http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html

APPENDIX: Reference Slides

Value Modifier Policies for 2015, 2016 & 2017

Value Modifier Components	2015 Finalized Policies	2016 Finalized Policies	2017 Proposed Policies
Performance Year	2013	2014	2015
Group Size	100+ EPs	10+ EPs	2+ EPs and solo practitioners
Quality-Tiering	**Optional:** Groups with 100+ EPs that elect quality-tiering can receive upward, neutral, or downward VM adjustment.	**Mandatory:** Groups with 10-99 EPs receive only the upward or neutral VM adjustment (no downward adjustment). Groups with 100+ EPs can receive upward, neutral, or downward VM adjustment.	**Mandatory:** Groups with 2-9 EPs and solo practitioners receive only the upward or neutral VM adjustment (no downward adjustment). Groups with 10+ EPs can receive upward, neutral, or downward VM adjustment.
Available Quality Reporting Mechanisms	GPRO-Web Interface, Qualified PQRS Registry, Administrative Claims	GPRO-Web Interface, Qualified PQRS Registry, EHR, and 50% of EPs reporting individually	Same as 2016

Value Modifier Policies for 2015, 2016 & 2017 (cont.)

Value Modifier Components	2015 Finalized Policies	2016 Finalized Policies	2017 Proposed Policies
Outcome Measures **NOTE:** The performance on the outcome measures and measures reported through one of the PQRS reporting mechanisms will be used to calculate a quality composite score for the TIN for the VM.	• All Cause Readmission • Composite of Acute Prevention Quality Indicators: (bacterial pneumonia, urinary tract infection, dehydration) • Composite of Chronic Prevention Quality Indicators: (chronic obstructive pulmonary disease (COPD), heart failure, diabetes)	Same as 2015	Same as 2015
Patient Experience of Care Measures	N/A	CAHPS for PQRS: Optional for groups with 25+ EPs; Required for groups with 100+ EPs reporting via Web Interface	CAHPS for PQRS: Optional for groups with 2-99 EPs; Required for all groups with 100+ EPs

Value Modifier Policies for 2015, 2016 & 2017 (cont.)

Value Modifier Components	2015 Finalized Policies	2016 Finalized Policies	2017 Proposed Policies
Cost Measures	• Total per capita costs measure (annual payment standardized and risk-adjusted Part A and Part B costs) • Total per capita costs for beneficiaries with four chronic conditions: COPD, Heart Failure, Coronary Artery Disease, Diabetes	• Same as 2015, and • Medicare Spending Per Beneficiary measure (includes Part A and B costs during the 3 days before, through 30 days after discharge following an inpatient hospitalization)	Same as 2016
Benchmarks	Group Comparison	Specialty Adjusted Group Cost	Specialty Adjusted Group Cost
Payment at Risk	-1.0%	-2.0%	-4.0%
Application of the VM to Participants of the Shared Savings Program, Pioneer ACO Model, and the CPC Initiative	Not Applicable	Not Applicable	Applicable

Value Modifier Policies for 2015, 2016 & 2017 (cont.)

Value Modifier Components	2015 Current Policy	2015 Proposed Policy	2016, 2017 Proposed Policy
VM Informal Review Process: Timeline	Not specified. After the dissemination of the annual Physician Feedback reports, a group of physicians may contact CMS to inquire about its report and the calculation of the value-based payment modifier.	• Deadline of January 31, 2015 for a group to request correction of a perceived error made by CMS in the 2015 VM payment adjustment. • Alternatively, we seek comment on a deadline of no later than the end of February 2015 to align with the PQRS informal review process.	Establish a 30 day period that would start after the release of the QRURs for the applicable reporting period for a group or solo practitioner (as applicable) to request correction of a perceived error made by CMS in the determination of the group or solo practitioner's VM for that payment adjustment period.
VM Informal Review Process: If CMS made an error	Not specified	• Classify a TIN as "average quality" in the event we determine that we have made an error in the calculation of quality composite. • Recompute a TIN's cost composite if CMS made an error in its calculation. • Adjust a TIN's quality tier.	• Recompute a TIN's quality composite in the event we determine that we have made an error in the calculation of quality composite. • Otherwise, the same as 2015.

Summary of Proposed Policies for Groups and Solo Practitioners with Shared Savings Program Participation Changes

Scenario	TIN's Status During the Performance Period (for example, CY 2015)	TIN's Status During the Payment Adjustment Period (for example, CY 2017)	TIN's Quality Composite for the Payment Adjustment Period (for example, CY 2017)	TIN's Cost Composite for the Payment Adjustment Period (for example, CY 2017)
A. Continued ACO participation - TIN A participates in ACO 1 during both the performance and payment adjustment periods.	TIN A is part of ACO 1	TIN A is part of ACO 1	Based on ACO 1's quality data from the performance period (for example, CY 2015)	Average cost
B.Joining an existing ACO and not from another ACO - TIN A was not part of any ACO during the performance period, but participates in ACO 1 during the payment adjustment period (ACO 1 existed in the performance period) **OR** **Joining an existing ACO from another ACO - TIN A participated in ACO 2 during the performance period, but is part of ACO 1 during the payment adjustment period (ACO 1 existed in the performance period)**	TIN A is not part of any ACO and ACO 1 exists **OR** TIN A is not part of ACO 2 and ACO 1 exists	TIN A is part of ACO 1	Based on ACO 1's quality data from the performance period (for example, CY 2015)	Average cost

Summary of Proposed Policies for Groups and Solo Practitioners with Shared Savings Program Participation Changes (cont.)

Scenario	TIN's Status During the Performance Period (for example, CY 2015)	TIN's Status During the Payment Adjustment Period (for example, CY 2017)	TIN's Quality Composite for the Payment Adjustment Period (for example, CY 2017)	TIN's Cost Composite for the Payment Adjustment Period (for example, CY 2017)
C. Joining a new ACO as a new TIN – TIN A participates in ACO 1 during the payment adjustment period (ACO 1 and TIN A did not exist in the performance period) **OR** **Joining a new ACO and not from another ACO - TIN A was not part of any ACO during the performance period, but participates in ACO 1 during the payment adjustment period (ACO 1 did not exist in the performance period)** **OR** **Joining a new ACO from another ACO – TIN A participated in ACO 2 during the performance period, but is part of ACO 1 during the payment adjustment period (ACO 1 did not exist in the performance period)**	TIN A and ACO 1 did not exist **OR** TIN A is not part of any ACO and ACO 1 did not exist **OR** TIN A is part of ACO 2 and ACO 1 did not exist	TIN A is part of ACO 1	Average quality	Average cost
D. Dropping out of an ACO - TIN A participated in ACO 1 during the performance period, but is not part of any ACO during the payment adjustment period	TIN A is part of ACO 1	TIN A is not part of any ACO	Average quality	Based on TIN A's cost data for the performance period using the quality-tiering methodology

Summary of Proposed Policies for Groups and Solo Practitioners with Pioneer ACO Model, CPC Initiative, or Other Similar Innovation Center Model or CMS Initiative Participation Changes

Scenario	TIN's Status During the Performance Period (for example, CY 2015)	TIN's Status During the Payment Adjustment Period (for example, CY 2017)	TIN's Quality Composite for the Payment Adjustment Period (for example, CY 2017)	TIN's Cost Composite for the Payment Adjustment Period (for example, CY 2017)
A. Scenario 1: TIN A participates in the Pioneer ACO Model or the CPC Initiative during the performance period, but does not participate in the Shared Savings Program or other similar Innovation Center models or CMS initiatives during the payment adjustment period (some or all of the eligible professionals in TIN A participate in the Pioneer ACO Model or CPC Initiative) AND **TIN A registers for PQRS GPRO for the performance period**	TIN A is part of the Pioneer ACO Model or CPC Initiative	TIN A is not part of the Shared Savings Program or other similar Innovation Center models or CMS initiatives	If TIN A satisfactorily reports PQRS GPRO data for the performance period: • Based on TIN A's PQRS GPRO data If TIN A does not satisfactorily report under PQRS GPRO for the performance period: • TIN A falls in Category 2 and a -4.0 percent VM will be applied to the TIN in the payment adjustment period	If TIN A satisfactorily reports under PQRS GPRO data for the performance period using the quality-tiering methodology

Summary of Proposed Policies for Groups and Solo Practitioners with Pioneer ACO Model, CPC Initiative, or Other Similar Innovation Center Model or CMS Initiative Participation Changes (cont.)

Scenario	TIN's Status During the Performance Period (for example, CY 2015)	TIN's Status During the Payment Adjustment Period (for example, CY 2017)	TIN's Quality Composite for the Payment Adjustment Period (for example, CY 2017)	TIN's Cost Composite for the Payment Adjustment Period (for example, CY 2017)
A. Scenario 2: TIN A participates in the Pioneer ACO Model or the CPC Initiative during the performance period, but does not participate in the Shared Savings Program or other similar Innovation Center models or CMS initiatives during the payment adjustment period (TIN A has one or more eligible professionals that participate in the Pioneer ACO Model or CPC Initiative and other non-participating eligible professionals) **AND** **For the performance period: TIN A does not report under PQRS GPRO; some eligible professionals report quality data to the Pioneer ACO Model or the CPC Initiative and others report under PQRS as individuals**	TIN A is part of the Pioneer ACO Model or CPC Initiative	TIN A is not part of the Shared Savings Program, or other similar Innovation Center models or CMS initiatives	If at least 50 percent of <u>all</u> eligible professionals in TIN A satisfactorily report quality data to CMS for the performance period: • Higher of "average quality" or the actual classification based on PQRS quality data submitted by the eligible professionals as individuals If less than 50 percent of <u>all</u> eligible professionals in TIN A satisfactorily report quality data to CMS for the performance period: • TIN A falls in Category 2 and a -4.0 percent VM is applied to the TIN in the payment adjustment period	If at least 50 percent of <u>all</u> eligible professionals in TIN A satisfactorily report quality data to CMS for the performance period: • Based on TIN A's cost data for the performance period using the quality-tiering methodology

Summary of Proposed Policies for Groups and Solo Practitioners with Pioneer ACO Model, CPC Initiative, or Other Similar Innovation Center Model or CMS Initiative Participation Changes (cont.)

Scenario	TIN's Status During the Performance Period (for example, CY 2015)	TIN's Status During the Payment Adjustment Period (for example, CY 2017)	TIN's Quality Composite for the Payment Adjustment Period (for example, CY 2017)	TIN's Cost Composite for the Payment Adjustment Period (for example, CY 2017)
A. Scenario 3: TIN A participates in the Pioneer ACO Model or the CPC Initiative during the performance period, but does not participate in the Shared Savings Program or other similar Innovation Center models or CMS initiatives during the payment adjustment period (all eligible professionals in TIN A participate in the Pioneer ACO Model or CPC Initiative) **AND** **For the performance period: TIN A does not report under PQRS GPRO; TIN A reports quality data to the Pioneer ACO Model or the CPC Initiative**	TIN A is part of the Pioneer ACO Model or CPC Initiative	TIN A is not part of the Shared Savings Program or other similar Innovation Center models or CMS initiatives	If TIN A successfully reports quality data to the Pioneer ACO Model or CPC Initiative for the performance period: Average quality If TIN A does not successfully report quality data to the Pioneer ACO Model or CPC Initiative for the performance period: TIN A falls in Category 2 and a -4.0 percent VM is applied to the TIN in the payment adjustment period	If TIN A successfully reports quality data to the Pioneer ACO Model or CPC Initiative for the performance period: Based on TIN A's cost data for the performance period using the quality-tiering methodology
B. TIN A participates in the Pioneer ACO Model or the CPC Initiative during the performance period and participates in other similar Innovation Center models or CMS initiatives during the payment adjustment period (but not the Shared Savings Program)	TIN A is part of the Pioneer ACO Model or CPC Initiative	TIN A is part of other similar Innovation Center models or CMS initiatives (but not the Shared Savings Program)	Based on scenarios 1-3	Average cost

Summary of Proposed Policies for Groups and Solo Practitioners with Pioneer ACO Model, CPC Initiative, or Other Similar Innovation Center Model or CMS Initiative Participation Changes (cont.)

Scenario	TIN's Status During the Performance Period (for example, CY 2015)	TIN's Status During the Payment Adjustment Period (for example, CY 2017)	TIN's Quality Composite for the Payment Adjustment Period (for example, CY 2017)	TIN's Cost Composite for the Payment Adjustment Period (for example, CY 2017)
C. TIN A participates in the Pioneer ACO Model or the CPC Initiative during the performance period and participates in an ACO under the Shared Savings Program during the payment adjustment period	TIN A is part of the Pioneer ACO Model or CPC Initiative	TIN A is part of an ACO under the Shared Savings Program	Based on the Shared Savings Program ACO's quality data for the performance period If the ACO did not exist in the performance period: Average quality	Average cost

Phase In of the Application of the Value Modifier

2015 – Voluntary application to physicians in 100+ groups

- For groups that do not avoid the 2015 PQRS payment adjustment: -1%
- Quality tiers for groups of 100+ that elected quality training, registered for the PQRS as a group and reported at least one measure or elected the PQRS administrative claims option:

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

2016 – Mandatory for physicians in 10+ groups, no negative adjustments for physicians in groups of 10-99 that avoid the PQRS adjustment

- For groups that do not avoid the 2016 PQRS payment adjustment: -2%
- Quality tiers for groups that avoid the 2016 PQRS payment adjustment:

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

** Groups and solo practitioners are eligible for an additional +1.0 x AF if they report PQRS quality measures and their average beneficiary risk score is in the top 25 percent of all beneficiary risk scores nationwide. The precise size of the reward for higher-performing groups will vary from year to year, based on an adjustment factor (AF) derived from actuarial estimates of projected billings.*

Phase In of the Application of the Value Modifier (cont.)

2017 – PROPOSED – Mandatory for all physicians and non-physician eligible practitioners, no negative adjustments for practices with 1-9 that avoid the 2017 PQRS payment adjustment

- For groups that do not avoid the 2017 PQRS payment adjustment: -4%
- Quality tiers for groups and solo practitioners that avoid the 2017 PQRS payment adjustment:

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+2.0 x AF*	+4.0 x AF*
Average Cost	-2.0%	+0.0%	+2.0 x AF*
High Cost	-4.0%	-2.0%	+0.0%

* Groups and solo practitioners are eligible for an additional +1.0 x AF if they report PQRS quality measures and their average beneficiary risk score is in the top 25 percent of all beneficiary risk scores nationwide. The precise size of the reward for higher-performing groups will vary from year to year, based on an adjustment factor (AF) derived from actuarial estimates of projected billings.