

2015 Medicare Physician Fee Schedule (MPFS) Final Rule

December 2, 2014

The Medicare Learning Network®



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Agenda

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

2017 Payment Adjustments

2017 Payment Adjustments

Program	Applicable to	Adjustment Amount	Based on PY
PQRS	All eligible professionals (EPs)	-2.0% 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 Payment Modifier	All physicians in groups with 2+ EPs and physicians who are solo practitioners	<p>Mandatory Quality-Tiering for PQRS reporters-</p> <p>Groups with 2-9 EPs and solo practitioners: Upward or neutral VM adjustment only based on quality-tiering (+0.0% to +2.0x of MPFS)</p> <p>Groups with 10+ EPs: Upward, neutral, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x of MPFS)</p> <p>Groups and solo practitioners receiving an upward adjustment are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25% of all beneficiary risk scores nationwide.</p> <p>Non-PQRS reporters-</p> <p>Groups with 2-9 EPs and solo practitioners: automatic -2.0% of MPFS downward adjustment</p> <p>Groups with 10+ EPs: Automatic -4.0% of MPFS downward adjustment</p>	2015

PQRS

PQRS Updates

- The 2015 MPFS Final Rule outlines updates to the PQRS.

CMS has not finalized any updates for the claims-based reporting mechanism.

EPs in Critical Access Hospitals billing method II are able to participate in PQRS using ALL reporting mechanisms, including claims.

Modify the deadline for group practice registration in the Physician Value-Physician Quality Reporting System (PV-PQRS) registration system to June 30th of the year in which the reporting period occurs.

Measure-applicability validation (MAV) process will now check whether an EP or a group practice should have reported on any of the cross-cutting measures.

Measure Updates

- The 2015 MPFS Final Rule outlines updates to the quality measures.

Measures Added

- 23 Measures for Individual and Measures Groups Reporting
- 2 new Measures Groups available for PQRS reporting beginning in 2015:
 - Sinusitis
 - Otitis (AOE)

Removal From PQRS

- 50 Measures to be removed
- 38 Measures within Measures Group
- 4 Measures Groups to be removed:
 - Perioperative Care
 - Back Pain
 - Cardiovascular Prevention
 - Ischemic Vascular Disease

Final Changes to the Measures Groups

- Removed 6-month reporting option for 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

Qualified Registry Updates

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

Extend the deadline for qualified registries to submit quality measures data, including, but not limited to, calculations and results, to March 31, 2016, for reporting periods ending in 2015.

QCDR Updates

Increase to 30, the limit on the number of non-PQRS measures that a Qualified Clinical Data Registry (QCDR) may submit on behalf of an EP.

Report on at least 2 outcome measures (or if less than 2 outcome measures, report on at least 1 outcome measures and at least 1 of the following types of measures: patient safety, resource use; patient experience of care; or efficiency/appropriate use).

Direct EHR and EHR Data Submission Vendor (DSV) Updates

An EP's certified EHR technology (CEHRT) does not need to be tested and certified to the most recent version of measures.

Web Interface Updates

If a group practice does not have any Medicare patients for any of the GPRO measures, the group practice will not meet the criteria for satisfactory reporting using the web interface (WI).

Group practices of 25 or more must report on all measures in the WI; AND populate data fields for the first 248 consecutively ranked in the group's sample for each module or preventive care measure. If less than 248, the group practice would report on 100 percent of assigned beneficiaries.

CAHPS for PQRS Updates

Consumer Assessment of Healthcare Providers & Systems (CAHPS) for PQRS required for group practices of 100+ EPs

CAHPS for PQRS is optional for group practices of 2-24 EPs and 25-99 EPs.

Beginning in 2015, group practices will be required to contract with a CMS Certified Vendor. Group practices will be required to bear the cost of administering the CAHPS for PQRS survey measures as it is no longer be feasible for CMS to bear the cost of group practices of 100 or more EPs to report the CAHPS.

2015 Medicare Electronic Health Record (EHR) Incentive Program

Medicare EHR Incentive Program Update

- The 2015 MPFS Final Rule outlines further expansion of the Medicare EHR Incentive Program

Comprehensive Primary Care Initiative (CPC) Reporting

- CPC 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
- Finalized PFS rule for CY 2015 only to allow CPC practice sites to report 9 of 11 measures from at least 2 NQS domains because practice sites may not have measures to cover 3 domains

Medicare Shared Savings Program

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

Public Reporting

Public Reporting Update

- The 2015 final rule outlines further expansion of public reporting on Physician Compare.

Groups

- All PQRS GPRO measures via the GPRO Web Interface, Registry, & EHR and all ACO measures
- Consumer Assessment of Healthcare Providers & Systems (CAHPS) for PQRS and CAHPS for ACOs

Individuals

- All 2015 individual PQRS measures via Registry, EHR, & Claims.
- 2015 QCDRs Measures Data
 - Individual EP-level
 - PQRS and Non-PQRS
 - No first year measures

Value-Based Payment Modifier

VM Updates

- The 2015 PFS Final rule further expands the application of the Value-based Payment Modifier (VM) in CY 2017

The 2015 PFS Final rule further expands the application of the Value-based Payment Modifier in CY 2017

Groups with 2-9 EPs and solo practitioners receive only the upward or neutral VM adjustment under quality-tiering;

Groups with 10+ EPs can receive upward, neutral, or downward VM adjustment under quality-tiering

The potential adjustment amounts vary by group size

VM will apply to physicians in TINs that participate in the Shared Savings Program, Pioneer ACO Model, CPC Initiative, or other similar innovation center models or CMS initiatives during the CY 2015 performance period

CY 2018 payment adjustments will apply to non-physician EPs in groups with 2+ EPs and to non-physician EPs who are solo practitioners based on performance during CY 2016

Value Modifier and the PQRS

For CY 2017 payment adjustment, physician solo practitioners and physician groups with 2+ EPs

PQRS Reporters – 3 types

- 1a. Group reporters – Register for GPRO Web Interface, Registry, or EHR AND meet the criteria to avoid the 2017 PQRS payment adjustment
OR
1b. Individual reporters in the group – at least 50% of EPs in the group report PQRS measures as individuals AND meet the criteria to avoid the 2017 PQRS payment adjustment.
2. Physician Solo practitioners - Report PQRS measures as individuals AND meet the criteria to avoid the 2017 PQRS payment adjustment.

Mandatory Quality-Tiering Calculation

Groups with 2-9 EPs and solo practitioners

Upward or neutral VM adjustment based on quality-tiering (+0.0% to +2.0x of MPFS)

Groups with 10+ EPs

Upward, neutral, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x of MPFS)

Non-PQRS Reporters

Do not register for GPRO Web Interface, registry, or EHR or 50% EP threshold **OR** do not avoid the 2017 PQRS payment adjustment

-2.0% (for groups with 2-9 EPs and solo practitioners)
-4.0% (for groups with 10+ EPs)
(Automatic VM downward adjustment)

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

2017 VM Policies for Groups with 2-9 EPs and Solo Practitioners

- The automatic downward adjustment for not successfully reporting PQRS is -2.0%
- Under quality-tiering, the potential upward adjustment is up to +2.0x ('x' represents the upward payment adjustment factor).
- Groups with 2-9 EPs and physician solo practitioners can earn only an upward or neutral (no) adjustment under quality tiering in 2017.

Final Rule CY 2017 VM Amounts

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%

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

2017 VM Policies for Groups with 10+ EPs

- The automatic downward adjustment for not successfully reporting PQRS is -4.0%
- Under quality-tiering, the potential upward adjustment is up to +4.0x ('x' represents the upward payment adjustment factor). The payment at risk is -4.0%.

Final Rule 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 measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores

2017 VM Policies for Shared Savings Program Participants

- Groups and solo practitioners participating in an ACO under the Shared Savings Program in the CY 2015 performance period will have their Value Modifier calculated as follows for the CY 2017 payment adjustment period:
 - Cost Composite: Average
 - Quality Composite: Based on ACO's quality data*
- *Determination of whether a group or solo practitioner is an ACO participant will be based on where the ACO participant is in the performance year and not the payment adjustment year.
- *We will apply the VM benchmarks to the ACO's quality data submitted through the GPRO web interface and will use the ACO all cause hospital readmission measure as calculated under the Shared Savings Program
- If the ACO fails to successfully report on quality measures, all groups and solo practitioners under the ACO will fall in Category 2 and be subject to the automatic downward adjustment described on slide 21 (The Value Modifier and the PQRS).

2017 VM Policies for Pioneer ACO Model, Comprehensive Primary Care (CPC) Initiative, and other similar initiative Participants

Pioneer ACO Model and CPC Initiative

- Physician solo practitioners and physician groups in which at least one eligible professional participates in the Pioneer ACO Model or CPC Initiative in 2015 will have their Value Modifier calculated as follows for 2017:
 - Cost Composite: Average
 - Quality Composite: Average
- Solo practitioners and groups in which at least one eligible professional participates in the Pioneer ACO Model or CPC Initiative in 2015 will be classified as Category 1 and will not be subject to the VM downward adjustment for CY 2017.

Similar Innovation Center models and CMS initiatives

- If a model or initiative is determined to be “similar” based on the criteria in the CY 2015 PFS final rule, physician solo practitioners and physician groups in which at least one eligible professional participates in the model or initiative in the performance period will be assessed under the same policies as Pioneer ACO and CPC Initiative participants.

2017 VM Quality & Cost Measures Updates

- CMS will continue to use all of the quality measures that are available via the various PQRS reporting mechanisms (GPRO Web-Interface, Registry, Qualified Clinical Data Registry, Electronic Health Records) to calculate a physician group or physician solo practitioner's CY 2017 payment adjustment.
- CMS will continue to use 3 claims-based outcomes measures:
 - Composite of Acute Prevention Quality Indicators
 - Composite of Composite of Chronic Prevention Quality Indicators:
 - All-Cause Hospital Readmission Measure

Note: We have changed to attribution methodology for these measures to remove the pre-step and include NPs, PAs, and CNSs in the first step of the attribution process
- Groups of 2 or more eligible professionals can still elect to include the patient experience of care measures collected through the PQRS CAHPS survey for CY 2015 in their CY 2017 VM
- Beginning with the CY 2017 payment adjustment period, we will increase the case minimum from 20 to 200 cases for the all-cause hospital readmission measure.

2017 VM Cost Measures Updates

- CMS will use the same specialty adjusted cost measures for the 2017 VM as it will for the 2016 VM:
 - Total per Capita Cost Measure
 - Per capita cost measures for beneficiaries with four specific chronic conditions (Diabetes, Heart Failure, Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD))
 - Note: We have changed to attribution methodology for these measures to remove the pre-step and include NPs, PAs, and CNSs in the first step of the attribution process
 - Medicare Spending per Beneficiary Measure
- Beginning with the CY 2017 payment adjustment period (CY 2015 performance period) we refined the attribution methodology for the five total per capita cost measures:
 - Removed the “pre-step” in which we required that a beneficiary have at least one charge by a physician in the group to be eligible for attribution to that group
 - Moved NPs, PAs, and CNSs to step 1 of the attribution methodology
 - Include certain part-year beneficiaries (newly eligible beneficiaries and those at the end of life)

Expansion of the Informal Inquiry Process for the Value-Based Payment Modifier

- For the CY 2015 payment adjustment period we finalized:
 - A February 28, 2015 deadline for a group to request correction of a perceived data error made by CMS in the determination of its VM
 - A policy to classify a TIN as “average quality” in the event CMS determines we made an error in the calculation of the quality composite
 - For 2015 and beyond, if CMS determines an error in the calculation of the cost composite we will re-compute the cost composite to correct the error
 - Beginning with the CY 2016 payment adjustment period:
 - The deadline to submit informal review requests will be 60 calendar days after the release of the QRURs for the applicable performance year
 - Starting in CY 2016 we plan to re-compute the quality composite to correct certain errors made by CMS or a third-party vendor.
- *In the event that it is not possible to re-compute the quality composite we will continue the approach for the CY 2015 payment adjustment period (as noted above).

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.
- 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 aligns with the following quality reporting programs for EPs participating in ACOs:
 - PQRS
 - EHR Incentive Program
 - Value-based Payment Modifier

Shared Savings Program Regulatory Updates

Quality Measures:

- Update the quality measure set to:
 - Incorporate more claims-based outcome measures that focus on care coordination and patient safety
 - Skilled Nursing Facility 30 Day All-Cause Readmission
 - All Cause Unplanned Admission for Patients with Diabetes
 - All Cause Unplanned Admission for Patients with Heart Failure
 - All Cause Unplanned Admission for Patients with Multiple Chronic Conditions
 - Remove redundant measures
 - Remove clinically outdated measures
 - Align with PQRS, VM, and EHR Incentive Program measures
 - Added Stewardship of Patient Resource to ACO CAHPS survey
- The total number of quality measures in the measure set remain at 33 across 4 domains.

Quality Assessment and Scoring

- Revised the quality scoring strategy to recognize and reward ACOs that make year-to-year improvements in quality performance scores in each domain. Increase quality improvement points to 4 points per domain
- Modified the benchmarking methodology to take into account “topped out” measures.
- Benchmarks will be updated every 2 years.
- Newly introduced measures will be pay-for-reporting for 2 years before being used for pay-for-performance.
- An ACO's quality performance in subsequent agreements will be assessed based on the standard that would apply to the third year of their first agreement period.

Alignment with other CMS quality reporting initiatives

- Continue to align with PQRS. Reduced the number of web interface measures from 22 to 17. Reduced the required number of consecutive patients to be reported from 411 to 248 per module/measure.
- Continue to align with the EHR Incentive program by codifying the requirements for participating EPs to meet the eCQMs when the ACO reports quality on their behalf.

Resources

Acronyms in this Presentation

- ACO: Accountable Care Organization
- CAHPS: Consumer Assessment of Healthcare Providers & Systems
- CEHRT: Certified EHR Technology
- CMS: Centers for Medicaid and Medicare Services
- CPC: Comprehensive Primary Care Initiative
- EHR: Electronic Health Record
- EP: Eligible Professional
- FAQ: Frequently Asked Questions
- FFS: Fee-for-Service
- GPRO: Group Practice Reporting Option
- MAV: Measure Applicability Validation
- MLN: Medicare Learning Network
- MPFS: Medicare Physician Fee Schedule
- PQRS: Physician Quality Reporting System
- PV-PQRS: Physician Value-Physician Quality Reporting System
- QCDR: Qualified Clinical Data Registry
- QRUR: Quality and Resource Use Report
- TIN: Taxpayer Identification Number
- VM: Value-based Payment Modifier
- WI: Web Interface

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 gnetsupport@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

- **Comprehensive Primary Care (CPC) Initiative Help Desk:**

800-381-4724 or cpcisupport@telligen.org

- **Physician Value Help Desk (for VM questions)**

Monday – Friday: 8:00 am – 8:00 pm EST

Phone: 888-734-6433, press option 3

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- To complete the evaluation, visit <http://npc.blhtech.com/> and select the title for today's call.

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- To obtain continuing education credit
 - Review CE Activity Information & Instructions for specific details: <http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/TC-L12022014-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 , please visit <http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html>.

Question & Answer Session

Resources

- **2015 MPFS Final Rule**
<https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-26183.pdf>
- **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>
- **Federal Register**
<https://www.federalregister.gov/public-inspection>
- **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/PhysicianFeedbackProgram/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

Appendices

Appendix A: Summary of Requirements for the 2017 PQRS Payment Adjustment

Individual Reporting Criteria via Claims, Qualified Registry, and EHRs and Satisfactory Participation Criterion in QCDRs

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting/Satisfactory Participation Criteria
12-month (Jan 1–Dec 31, 2015)	Individual Measures	Claims	Report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the eligible professional sees at least 1 Medicare patient in a face-to-face encounter, the eligible professional will report on at least 1 measure contained in the proposed cross-cutting measure set specified in Table 52. If less than 9 measures apply to the eligible professional, the eligible professional would report up to 8 measure(s), AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.
12-month (Jan 1–Dec 31, 2015)	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the eligible professional sees at least 1 Medicare patient in a face-to-face encounter, the eligible professional will report on at least 1 measure contained in the proposed cross-cutting measure set specified in Table 52. If less than 9 measures apply to the eligible professional, the eligible professional would report up to 8 measure(s), AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.

Appendix A: Summary of Requirements for the 2017 PQRS Payment Adjustment (cont.)

Individual Reporting Criteria via Claims, Qualified Registry, and EHRs and Satisfactory Participation Criterion in QCDRs

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

Appendix A: Summary of Requirements for the 2017 PQRS Payment Adjustment (cont.)

Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Satisfactory Reporting/Satisfactory Participation Criteria
12-month (Jan 1–Dec 31, 2015)	25-99 eligible professionals	Individual GPRO Measures in the GPRO Web Interface	GPRO Web Interface	Report on all measures included in the web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100 percent of assigned beneficiaries. In other words, we understand that, in some instances, the sampling methodology we provide will not be able to assign at least 248 patients on which a group practice may report, particularly those group practices on the smaller end of the range of 25–99 eligible professionals. If the group practice is assigned less than 248 Medicare beneficiaries, then the group practice must report on 100 percent of its assigned beneficiaries. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31, 2015)	25-99 eligible professionals and 100+ eligible professionals	Individual GPRO Measures in the GPRO Web Interface +CAHPS for PQRS	GPRO Web Interface + CMS Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS certified survey vendor. In addition, the group practice must report on all measures included in the GPRO web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100 percent of assigned beneficiaries. A group practice will be required to report on at least 1 measure for which there is Medicare patient data.

Appendix A: Summary of Requirements for the 2017 PQRS Payment Adjustment (cont.)

Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Satisfactory Reporting/Satisfactory Participation Criteria
12-month (Jan 1–Dec 31, 2015)	2-99 eligible professionals	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the NQS domains. Of these measures, if a group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice would report on at least 1 measure in the cross-cutting measure set specified in Table 52. If less than 9 measures covering at least 3 NQS domains apply to the group practice, the group practice would report up to 8 measures covering 1–3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the group’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.
12-month (Jan 1–Dec 31, 2015)	2-99 eligible professionals and 100+ eligible professionals	Individual Measures + CAHPS for PQRS	Qualified Registry + CMS Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS certified survey vendor, and report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 of the NQS domains using the qualified registry. If less than 6 measures apply to the group practice, the group practice must report up to 5 measures. Of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, if any eligible professional in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice must report on at least 1 measure in the cross-cutting measure set specified in Table 52.

Appendix A: Summary of Requirements for the 2017 PQRS Payment Adjustment (cont.)

Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO

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

Appendix B: Value Modifier Policies for 2015, 2016 & 2017

Value Modifier Components	2015 Finalized Policies	2016 Finalized Policies	2017 Finalized 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, CMS-calculated Administrative Claims	GPRO-Web Interface, Qualified PQRS Registry, EHR, or 50% of EPs report under the PQRS as individuals	Same as 2016

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

Value Modifier Components	2015 Finalized Policies	2016 Finalized Policies	2017 Finalized Policies
<p>Outcome Measures</p> <p>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.</p>	<ul style="list-style-type: none"> • 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	<p>CAHPS for PQRS: Optional for groups with 25+ EPs; Required for groups with 100+ EPs reporting via Web Interface.</p> <p>Groups may elect to include their CAHPS results in the calculation of the 2016 VM.</p>	<p>CAHPS for PQRS: Optional for groups with 2-99 EPs; Required for all groups with 100+ EPs.</p> <p>Groups may elect to include their CAHPS results in the calculation of the 2017 VM.</p>

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

Value Modifier Components	2015 Finalized Policies	2016 Finalized Policies	2017 Finalized Policies
Cost Measures	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	Cost: <ul style="list-style-type: none"> •100+ EP TINs are compared against groups of 100+ EPs •1-99 EP TINs are compared against 1+ EP TINs Quality: No differentiation by group size (“compared to everyone”)	No differentiation by group size (“compared to everyone”) for both cost and quality measures	No differentiation by group size (“compared to everyone”) for both cost and quality measures
Maximum Payment at Risk	-1.0%	-2.0%	-2.0% (Groups with 2-9 EPs and solo practitioners) -4.0% (Groups with 10+ EPs)
Application of the VM to Participants of the Shared Savings Program, Pioneer ACO Model, and the CPC Initiative	Not Applicable	Not Applicable	Applicable

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

Value Modifier Components	2015 Current Policy	2015 Finalized Policy	2016, 2017 Finalized 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.	<ul style="list-style-type: none"> Deadline of February 28, 2015 for a group to request correction of a perceived error made by CMS in the 2015 VM payment adjustment. 	Establish a 60 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	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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.