PHYSICIAN COMPARE WEBSITE (p. 676)

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>PROPOSED RULE</th>
<th>FINAL RULE</th>
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<tbody>
<tr>
<td>Public Reporting of Performance and Other Data (p. 676)</td>
<td>CMS’ proposed to continue it phased approach to the public reporting of physician performance data on the Physician Compare website. CMS also proposed to maintain minimum criteria for deeming measures suitable for public reporting. Even among measures deemed suitable for public reporting, CMS recognized that not all measure data will be appropriate for reporting on individual or group practice profile pages and should instead be included in a downloadable raw data file.</td>
<td>CMS’ phased approach to public reporting is outlined in Table 25 on p. 697. Table 26 on p. 728 summarizes the Physician Compare measure and participation data proposals finalized in this final rule. As previously finalized, the following information will be reported on Physician Compare in 2016 if it meets the established public reporting criteria described further below: • All 2015 group-level PQRS measures across all group reporting mechanisms –Web Interface, registry, and EHR – will be available for public reporting on Physician Compare in 2016 for groups of 2 or more EPs • Twelve 2015 CAHPS for PQRS summary survey measures for all group practices of two or more EPs, who meet the specified sample size requirements and collect data via a CMS-specified certified CAHPS vendor in 2016 • 2015 PQRS measures for individual EPs collected through a registry, EHR, or claims • Four 2015 PQRS measures reported by individual EPs in support of Million Hearts Campaign • 2015 Qualified Clinical Data Registry (QCDR) PQRS and non-PQRS measure data collected at the individual EP level by late 2016 [NOTE: The QCDR is required to declare during self-nomination if it plans to post data on its own website and allow Physician Compare to link to it or if it will provide data to CMS for public reporting on Physician Compare].</td>
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In response to concerns about this aggressive timeline, CMS noted its belief that it has taken a measured, phased approach to implementation and that this is simply the next step. It also clarified that transparency will remain key throughout the implementation of the Merit-Based Payment Incentive
In response to comments urging CMS to ensure that updates made in PECOS are reflected on Physician Compare within 30 days or that CMS develop a new mechanism for real-time address updates on the website, CMS noted its commitment to including accurate and up-to-date information on Physician Compare and to continuing to work to make improvements to the information presented.

Nevertheless, there is a lag between when an edit is made in PECOS and when that edit is processed by the MAC and available in the PECOS data pulled for Physician Compare. This is time necessary for data verification, which means a delay. CMS continues to work to find ways to minimize this delay, and noted that in the past year it reduced the data refresh cycle from monthly to bi-weekly to further improve data timeliness.

The website will continue to post annually the names of individual EPs who satisfactorily report under PQRS, EPs who successfully participate in the Medicare Electronic Health Record (EHR) Incentive Program, as well as EPs who report PQRS measures in support of Million Hearts.

In response to a request that CMS reconsider publicly reporting participation in the Medicare EHR Incentive Program due to ongoing issues related to the program, CMS decided to maintain this policy since this information is already reported and consumers find this information “interesting and helpful.”

CMS also clarified that it currently tests all information included on the website with consumers to ensure they understand the information provided. It recently focused testing on the quality initiative indicators and plain language updates are forthcoming as a result of this testing users so that users better understand the data presented.

CMS will continue its policy of only making measures available for public reporting if they prove to be valid, reliable, and accurate upon analysis and review at the conclusion of data collection, and those that prove to resonate with consumers. CMS will also continue to include an indicator of which reporting mechanism was used and to only include on the site measures deemed statistically comparable.

CMS will also maintain its policy of only reporting on measures that meet a
minimum sample size of 20 patients despite the majority of commenters criticizing the 20 patient threshold as too low to be statistically valid. CMS’ rationale is that it is a large enough sample to protect patient privacy for reporting on the website, and it is the threshold previously finalized for both the physician value-based payment modifier (VM) for most measures and the PQRS criteria for reporting measure groups. It’s also appropriate since all measures are subject to additional validity and reliability tests prior to being publicly reported even if the minimum sample threshold is met.

In response to requests that CMS publish the results of validity and reliability studies, as well as the methodology for choosing measures prior to posting on Physician Compare, CMS noted that it has outlined some of the types of reliability studies that are conducted for measures (see: 79 FR 67764 through 79 FR 67765). Additional information is also shared annually via its Technical Expert Panel (TEP) summaries, which can be found on the Physician Compare Initiative page on www.CMS.gov. CMS will evaluate the feasibility of this request to share additional information. It will evaluate the feasibility of sharing additional information about the testing done.

In response to requests for more information on its consumer concept testing plans, CMS continues to conduct consumer testing in terms of both usability testing -- to ensure the site is easy to navigate and functioning appropriately -- and concept testing -- to ensure users understand the information included on the website and that information included resonates with health care consumers and allows the website to accomplish the goals as stated. Once a set of measures is finalized as available for public reporting, CMS begins planning concept testing. Therefore, the measures finalized in this rule will be tested prior to publicly reporting in late 2017. CMS will also continue to work to ensure that all stakeholders, including consumers and health care professionals, are included in the testing and review process as appropriate and feasible.

In fulfilling its duties to consider input provided by multi-stakeholder groups when selecting measures for Physician Compare, CMS will continue to review recommendations from the public and strongly urges all stakeholders to regularly visit the Physician Compare Initiative (https://www.cms.gov/medicare/quality-initiatives-patient-assessmentinstruments/physician-compare-initiative/) for the latest opportunities to engage with the Physician Compare team.

CMS also noted concerns about including data in a downloadable raw data file if it has already been deemed unsuitable for profile pages and the fact
that it could be misused or misinterpreted. However, it ultimately decided to stick with its original proposal of including all measures that meet all stated public reporting standards in a downloadable file in order to further transparency. CMS will continue to limit the measures available on Physician Compare profile pages to those measures that meet these public reporting standards and are also of the greatest value to consumers through consumer testing. CMS feels there could be measures that may be difficult for consumers to understand, but that are still strong and provide valuable clinical information.

As previously finalized, EPs will be given a 30-day preview period to view their measures as they will appear on Physician Compare prior to being published. CMS will provide a detailed timeline and instructions for preview in advance of the start of the preview period. CMS acknowledged requests to extend this period and to allow EPs the opportunity to correct and/or appeal any errors found in the performance information before it is posted on the site, but clarified that there is currently no appeals process for data made public on Physician Compare. If an EP has any concerns regarding the data viewed during preview, they are provided with multiple options to reach out to the Physician Compare support team to report their concern and have the issue investigated (which would be addressed prior to publicly reporting of the data). CMS also noted that the PQRS and VM programs offer an annual Informal Review Period following the release of the Quality and Resource Use Reports (QRURS).

CMS also clarified that data collected at the individual EP level, whether through a QCDR or through other PQRS reporting mechanism will only be publicly reported at the individual EP level, and data collected at the group practice level will only be reported at the group practice level.

<table>
<thead>
<tr>
<th>Proposed Policies for Public Data Disclosure on Physician Compare (p.700)</th>
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<tr>
<td><strong>Value Modifier.</strong> CMS proposed to include annually a green check mark on individual and group practice profile pages who received an upward adjustment for the VM. This information would be based on 2016 data and included on the site no earlier than late 2017.</td>
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<td><strong>Value Modifier (p. 700).</strong> Due to significant concerns that the VM is not well understood by the public, may be misinterpreted, or does not provide value to consumers; concerns with the VM calculation methodology and the resulting proportion of health care professionals that receive “average” scores for the cost and/or quality composite; and the fact that the VM program will sunset after 2018 when MIPS is implemented, CMS opted NOT to finalize this proposal and thus, will NOT be including a visual indicator of the VM upward adjustment on profile pages at this time.</td>
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In response to requests that CMS add indicators for EPs who participate in a QCDR, participate in a quality improvement registry for other services, or participate in other voluntary quality improvement initiatives, CMS
Million Hearts. CMS proposed to include an indicator for individual EPs who satisfactorily report the new Cardiovascular Prevention measures group being proposed under PQRS.

PQRS GPRO and ACO Reporting. CMS proposed to continue to make available for public reporting on an annual basis the performance rate for all PQRS GPRO measures across all PQRS group practice reporting mechanisms – Web Interface, registry, and EHR– for groups of 2 or more EPs available in the year following the year the measures are reported.

Individual EP PQRS Reporting. CMS proposed to continue with its plans to publicly report on Physician Compare all 2015 PQRS measures for individual EPs collected through a registry, EHR, or claims. These measures would be available to the public annually in the year following the year the measures are reported. For individual EP measures, the measure performance rate would be represented on the website.

Individual EP and Group Practice Qualified Clinical Data Registry (QCDR) Measure Reporting. CMS proposed to continue to report on Physician Compare all individual EP level QCDR PQRS and non-PQRS measure data that have been collected for at least a full year. CMS proposed to also make group practice level QCDR measure data that have been collected for at least a full year available for public reporting.

Benchmarking. CMS proposed to use the Achievable Benchmark of Care (ABC™) methodology to generate a benchmark for publicly reported measures based on the PQRS performance rates most recently available (i.e., in 2017 CMS would publicly report a benchmark derived from the 2016 PQRS performance rates). The specific measures the benchmark would be derived for would be determined once the data are available and analyzed and the benchmark would only be applied to those measures deemed valid and reliable and that are reported by enough EPs or group practices to produce a valid result. This methodology uses a pared mean to respond that this is not something currently being considered since this is not a concept consumers are familiar with. However, CMS will take it into consideration for potential future evaluation.

Million Hearts (p. 702). CMS did we finalize its proposal to include a visual indicator on EP profile pages in support of the Million Hearts initiative as it is deemed valuable by consumers and including this information may incentivize health care professionals to focus on the Million Hearts measures.

PQRS GPRO and ACO Reporting (p. 703). CMS finalized its proposal to continue to make all PQRS group practice level and ACO Shared Savings Program measures available for public reporting annually, including making the 2016 PQRS group practice and ACO data available for public reporting on Physician Compare in late 2017.

Individual EP PQRS Reporting (p. 705). As a result of the comments received and the importance of individual EP level quality measure data to consumers, CMS finalized its proposal to continue to make all PQRS individual EP level PQRS measures available for public reporting annually, including making the 2016 PQRS individual EP level data available for public reporting on Physician Compare in late 2017.

Individual EP and Group Practice Qualified Clinical Data Registry (QCDR) Measure Reporting (p. 707). Recognizing the value of these data, the opportunity for these data to fill gaps currently in the PQRS program, and the relevancy of these data to many specialties, CMS is finalizing this proposal to make group practice and individual EP level QCDR data available for public reporting on Physician Compare annually, including making 2016 data available for public reporting in late 2017.

Benchmarking (p. 710). While there was support for the value of benchmarks, the public also voiced concern that it was too premature to publicly report a benchmark and suggested phasing in or testing the use of benchmark privately with EPs for internal improvement first prior to making the benchmark publicly available. Others asked for CMS to delay implementation until it has a better understanding of how it will work in the context of MIPS. Still others noted the need to stratify benchmarks by specialty, by reporting mechanism, and to risk-adjust the benchmark.

Other commenters suggested alternative benchmark methodologies,
produce a benchmark that represents the best care provided to the top 10% of patients. It also relies on an adjusted performance fraction (AFP) to ensure that very small sample sizes do not over-influence the benchmark. CMS also proposed to use the ABC™ methodology to systematically assign stars for a Physician Compare 5 star rating.

including an approach that recognizes self-improvement over time and peer-to-peer performance. One commenter asked for the opportunity to review the database and provide a clear demonstration of the benchmark’s validity. Still others felt the ABC™ methodology is too complex and will be difficult for consumers to understand, while others requested that CMS use consistent benchmarking across its programs. Finally, several commenters urged CMS to allow QCDRs to determine their own benchmark approach.

Despite these concerns and requests, CMS finalized its proposal to publicly report on Physician Compare an item, or measure-level, benchmark derived using the ABC™ methodology annually based on the PQRS performance rates most recently available stratified by reporting mechanism for both group practice and individual EP level measures. As with all information available for public reporting on Physician Compare, the benchmark information and the resulting star ratings need to meet the public reporting standards of statistically valid, accurate, reliable, and comparable data. CMS’ justification was the significant value of adding a benchmark to Physician Compare now since consumers need tools to best understand the data and to make accurate and appropriate comparisons.

While CMS agrees that risk adjustments are critical, it feels this should be approached at the measure development level rather than trying to adjust after the fact at the benchmarking stage.

CMS recognized the negative consequences of over-stratifying data, which is why it decided to only stratify by reporting mechanism at this time. [Note that this would only apply to PQRS data. QCDRs are free to develop their own benchmark methodology and submit their methodology and benchmark rates to Physician Compare for public reporting].

In regards to the star ratings, CMS acknowledged public opposition to star ratings and concerns that they oversimplify performance data and/or result in inappropriate distinctions of quality for physicians whose performance scores are not statistically different. Nevertheless, CMS believes this is a consumer friendly way to share complex information and that the goal of using a benchmark such as one derived from the ABC™ methodology is to have a star rating system that distinguishes statistically significant quality differences. CMS also noted that consumer testing in this realm is ongoing.

CMS will continue to conduct analyses to ensure that all data, including the benchmarks, are showing variation in performance and not in other factors, such as region or population of care. Similarly, CMS is conducting ongoing
testing evaluating this methodology as applied to the available PQRS data, and it will actively reach out to stakeholders to share information about the results of this statistical analysis, as well as ongoing consumer testing, to ensure stakeholders are aware of the specific application of the benchmark and the reliability, validity, and accuracy of the benchmark for the available PQRS process and outcome measures. CMS will use the most current data to ensure the benchmark is the best measure of timely quality care. Therefore, additional specifics about the application of the benchmark in terms of the specific star attribution, including but not limited to statistical analysis of the 2016 data, star display, and consumer testing, will depend on data that have not been collected yet. CMS will provide this information as it is available but in advance of publicly reporting the benchmark.

Patient Experience of Care Measures. CMS proposed to continue to make available for public reporting all patient experience data for all group practices of two or more EPs, who meet the specified sample size requirements and collect data via a CMS-specified certified CAHPS vendor, annually in the year following the year the measures are reported. CMS proposed to publicly report a representation of the top box performance rate for the 12 summary survey measures (i.e., CAHPS for PQRS). Top Box score refers to the most favorable response category for a given measure.

Patient Experience of Care Measures (p. 719). While some commenters supported the value of patient experience data, others citing concerns around consumer interpretation of patient reported data; that these data may not capture patient experience related to all specialties, such as hospitalists, other hospital-based professionals, and surgical practices; and that the “Stewardship of Patient Resources” measure because the measure does not address the numerous barriers to patients accessing to care. Several commenters supported adding other types of patient experience data to Physician Compare, including Surgical CAHPS® and experience data collected via other sources, while others suggested reporting patient experience data for primary care physicians and only clinical quality performance for specialists.

CMS recognizes that not all measures under consideration for public reporting equally apply to all types of professionals included on Physician Compare. However, the agency believes that the CAHPS for PQRS measures apply to the large majority of professionals currently represented on the site. And while CMS appreciates comments regarding other types of patient experience data, it only pledged to consider these recommendations for the future.

Ultimately, CMS concluded that CAHPS for PQRS data are highly valued by consumers and finalized its proposal to make all twelve summary survey CAHPS for PQRS measures available for public reporting on Physician Compare annually for groups of 2 or more EPs reporting via a CMS certified CAHPS vendor.

Downloadable Database

Addition of Value Modifier Information. CMS proposed to add to the Physician Compare downloadable database the 2018 VM

Addition of Value Modifier Information (p. 721). Several commenters expressed significant concerns about adding this VM data to the Physician
### Quality Tiers for Cost and Quality

CMS also proposed to include a notation of the payment adjustment received based on the cost and quality tiers, and an indication if the individual EP or group practice was eligible to but did not report quality measures to CMS.

**Addition of Utilization Data.** Under MACRA, the Secretary is required to integrate utilization data information on Physician Compare beginning with 2016. Since these data are less immediately useable in their raw form by the average Medicare consumer, CMS proposed that the data be added to the downloadable database versus the consumer-focused website profile pages.

**Board Certification (p. 726).** CMS proposed to add to the website board certification information from the American Board of Optometry (ABO) and American Osteopathic Association (AOA).

While CMS appreciates that these data could be misused, it believes the benefits of transparency and potential learnings outweigh these concerns and that making these data available to the public could lead to improvements in the methodology and greater understanding of cost and quality. Stating its commitment to increased transparency, CMS opted to finalize this proposal to add cost and quality tier, as well as adjustment, information to the Physician Compare downloadable database for the 2018 VM based on 2016 quality and cost data.

**Addition of Utilization Data (p. 724).** Commenters expressed concern with the accuracy of these data and the potential for misinterpretation or misuse of the data. Some requested that these data include disclaimers about the limitations of utilization data and requested that physicians be allowed to submit corrections where the data are inaccurate or outdated. CMS appreciated these suggestions, but simply committed to reviewing them for the future.

Since this is mandated by MACRA and given CMS' ongoing transparency goals, CMS finalized its proposal to include utilization data in the Physician Compare downloadable database. Not all available data will be included. The specific HCPCS codes included will be determined based on analysis of the available data, focusing on the most used codes. Additional details about this process will be provided to stakeholders.

**Board Certification (p. 726).** CMS finalized this proposal.
Quality Measures. CMS sought comment on potential measures that would benefit from future policy reporting on Physician Compare.

Medicare Advantage. CMS sought comment on adding information on relevant EP and group practice profile pages about which Medicare Advantage health plans the EP or group accepts and linking this to more information about that plan on the Medicare.gov Plan Finder website. This was proposed since Medicare Advantage quality data is reported via Plan Finder at the plan level; physicians who participate in Medicare Advantage do not have quality measure data available for public reporting on Physician Compare.

Value Modifier. CMS sought comment on including in future years an indicator for a downward and neutral VM adjustment on group practice and individual EP profile pages, as well as including the VM quality and cost composites or other VM quality performance data on Physician Compare profile pages and/or the downloadable database.

Open Payments Data. CMS sought comment about including Open Payments data on individual EP profile pages, as feasible and appropriate.

Measure Stratification. CMS sought comment on including individual EP and group practice-level quality measure data stratified by race, ethnicity, and gender on Physician Compare, if feasible and appropriate. It also sought comment on potential quality measures, including composite measures, for future postings on Physician Compare that could help consumers and stakeholders monitor trends in health equity.

CMS will take the following public comments into consideration in the future:

Quality Measures. There was public support for: outcomes measures, including patient-reported outcomes; patient safety, care coordination, cross-cutting, and patient and family experience of care measures; appropriate access to care measures; specialty-specific measures; and a common set of EP level performance measures that could apply across all payment programs. The public also emphasized the importance of continued partnerships with professional associations in making these determinations.

Medicare Advantage. Many commenters opposed adding Medicare Advantage data due to concerns with data accuracy and comparison to FFS quality data.

Value Modifier. Several commenters opposed these potential future proposals due to concerns around the current VM methodology, the complexity of the program, and the meaningfulness of the cost and quality composite scores to consumers.

Open Payments Data. Public concerns included: data are already publicly available so adding these data to Physician Compare is redundant; requests that CMS provide context for the data to ensure correct interpretations; concern that Physician Compare serves a different purpose than the Open Payments website and it would be misleading to include this information on Physician Compare as it is unrelated to the quality of care; and concerns about the accuracy of Open Payments data.

Measure Stratification. The public is concerned about over-diluting the data, the data collection burden, and privacy issues. Also, calculation of stratified quality data would require significant research to ensure that the information provided was both meaningful and accurate.

Miscellaneous Comments: In response to requests for disclaimers or additional education to explain to consumers why a physician/specialty might not have quality data on the website and that this is not necessarily an indication of poor quality, CMS noted that it will continue to work to ensure that the language on Physician Compare addresses these concerns. CMS also hopes that the introduction of additional measures, such as QCDR measures and patient experience measures, will help to address this concern in the short term.
### PHYSICIAN QUALITY REPORTING SYSTEM (p. 738)

#### The Definition of EP for Purposes of Participating in the PQRS (p. 740)

<table>
<thead>
<tr>
<th>EPs in Critical Access Hospitals Billing under Method II (CAH-IIs):</th>
<th>EPs in CAH-IIs: Finalized as discussed in proposed rule.</th>
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<tbody>
<tr>
<td>EPs in critical access hospitals billing under Method II (CAH-IIs) were previously not able to participate in the PQRS. Due to a change made in the manner in which EPs in CAH-IIs are reimbursed by Medicare, it is now feasible for EPs in CAH-IIs to participate in the PQRS. EPs in CAH-IIs may participate in the PQRS using ALL reporting mechanisms available, including the claims-based reporting mechanism.</td>
<td>EPs Who Practice in RHCs and/or FQHCs: Finalized as discussed in proposed rule.</td>
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**EPs Who Practice in Rural Health Clinics (RHCs) and/or Federally Qualified Health Centers (FQHCs):** With respect to EPs who furnish covered professional services at RHCs and/or FQHCs that are paid under the Medicare PFS, CMS is currently unable to assess PQRS participation for these EPs due to the way in which these EPs bill for services under the PFS. Therefore, EPs who practice in RHCs and/or FQHCs would not be subject to the PQRS payment adjustment.

**EPs Who Practice in Independent Diagnostic Testing Facilities (IDTFs) and Independent Laboratories (ILs):** Due to the way IDTF and IL suppliers and their employee EPs are enrolled with Medicare and claims are submitted for services furnished by these suppliers and billed by the IDTF or IL, CMS is unable to assess PQRS participation for these EPs. Therefore, claims submitted for services performed by EPs who perform services as employees of, or on a reassignment basis to, IDTFs or ILs would not be subject to the PQRS payment adjustment.

#### QCDR Requirements (p. 743)

**Who May Self-Nominate to Become a QCDR.** CMS clarified the basic statutory definition of a QCDR, which is a CMS-approved entity that has self-nominated and successfully completed a qualification process showing that it collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. A QCDR must perform the following functions:

- Submit quality measures data or results to CMS for purposes of demonstrating that, for a reporting period, its EPs have satisfactorily participated in PQRS. A QCDR must...
have in place mechanisms for the transparency of data elements and specifications, risk models, and measures.

- Submit to CMS, for purposes of demonstrating satisfactory participation, quality measures data on multiple payers, not just Medicare patients.
- Provide timely feedback, at least four times a year, on the measures at the individual participant level for which the QCDR reports on the EP’s behalf for purposes of the individual EP’s satisfactory participation in the QCDR.
- Possess benchmarking capacity that compares the quality of care an EP provides with other EPs performing the same or similar functions.

CMS established further details regarding the requirements to become a QCDR in the CYs 2014 and 2015 PFS final rules. However, these requirements were not meant to prohibit entities that meet the basic definition of a QCDR from self-nominating to participate in the PQRS as a QCDR.

Self-nomination period. In response to feedback that more time is needed to self-nominate, and accounting for the fact that it is not technically feasible to extend the self-nomination deadline past January 31, CMS will open the QCDR self-nomination period on December 1 of the prior year to allow more time for entities to self-nominate, which would provide entities with an additional month to self-nominate. However, the deadline for an entity to submit a self-nomination statement is still January 31 of the year in which the clinical data registry seeks to be qualified.

Proposed Establishment of a QCDR Entity. CMS proposed to modify this policy so that an entity must be in existence as of January 1 of the year for which the entity seeks to become a QCDR, rather than January 1 of the year prior to.

Attestation Statements for QCDRs Submitting Quality Measures Data during Submission. Beginning in 2016, CMS proposed to allow QCDRs to attest via a web-based mechanism during the data reporting period that their quality measure results and any and all data, including numerator and denominator data, provided to CMS are accurate. Traditionally, this attestation had to be provided via a signed, written statement via email.

Self-nomination period. Finalized as proposed.

Proposed Establishment of a QCDR Entity. CMS does not believe a “waiting period” is necessary and finalized this policy as proposed. Therefore, for an entity to become qualified for 2016 it would have to be in existence as of January 1, 2016.

Attestation Statements for QCDRs Submitting Quality Measures Data during Submission. CMS finalized this proposal. As such, QCDRs will no longer be able to submit this attestation statement via email. This web-based check box mechanism will be available at: https://www.qualitynet.org/portal/server.pt/community/pqri_home/212.
Proposed Changes to Requirements for QCDRs: Submission of Quality Measures Data for Group Practices. CMS proposes that QCDRs have the ability to submit quality measures data for group practices, in addition to individuals, starting in 2016.

Self-Nomination Deadline. CMS also proposed to require that all documents that are necessary to analyze the vendor for qualification be provided to CMS no later than January 31 of the year in which the vendor intends to participate in the PQRS as a QCDR. Traditionally, vendors had until March 31 to submit measure information, but CMS proposed to move up this date due to issues it experienced related to measures data received during the 2013 reporting year.

Data Validation Requirements. A validation strategy details how the qualified registry will determine whether EPs and GPRO group practices have submitted data accurately and satisfactorily on the minimum number of their eligible patients, visits, procedures, or episodes for a given measure. Current guidance is available here: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_RegistryVendorCriteria.pdf

To help mitigate issues that may occur when collecting, calculating, and submitting quality measures data to CMS, the agency proposed additional requirements. Beginning in 2016, information that a QCDR must provide to CMS at the time of self-nomination to ensure that data submitted is valid, includes:

- Provide the method(s) by which the entity obtains data from its customers: claims, web-based tool, practice management system, EHR, other.
- If a combination of methods (Claims, Web Based Tool, Practice Management System, EHR, and/or other) is utilized, state which method(s) the entity utilizes to collect reporting numerator and denominator data.
- Indicate the method the entity will use to verify the accuracy of each TIN and NPI it is intending to submit (i.e., National Plan and Provider Enumeration System (NPPES), CMS claims, tax

Proposed Changes to Requirements for QCDRs: Submission of Quality Measures Data for Group Practices. CMS finalized this policy as proposed with little discussion.

Self-Nomination Deadline. Despite some concerns about the need for more time, CMS also finalized its proposal to require QCDR vendors to submit all documents for self-nomination by January 3, 2016 in an effort to prevent problems encountered in the past. This includes, but is not limited to, submission of the vendor’s data validation plan as well as the measure specifications for the non-PQRS measures the entity intends to report. Note that after the entity submits this information on January 31, it cannot later change any of the information it submitted to us for purposes of qualification. For example, once an entity submits measure specifications on non-PQRS measures, it cannot later modify the measure specifications the entity submitted. Please note that this does not prevent the entity from providing supplemental information if requested by CMS.

Data Validation Requirements. Despite requests for more time to implement these requirements and some concerns that these requirements were unnecessarily burdensome, CMS finalized this proposal, including the deadline to provide CMS with this information by June 30, 2016.
• Describe the method that the entity will use to accurately calculate both reporting rates and performance rates for measures and measures groups based on the appropriate measure type and specification. For composite measures or measures with multiple performance rates, the entity must provide us with the methodology the entity uses for these composite measures and measures with multiple performance rates.

• Describe the process that the entity will use for completion of a randomized audit of a subset of data prior to the submission to CMS. Periodic examinations may be completed to compare patient record data with submitted data and/or ensure PQRS measures were accurately reported based on the appropriate Measure Specifications (that is, accuracy of numerator, denominator, and exclusion criteria).

• If applicable, provide information on the entity’s sampling methodology. For example, it is encouraged that 3% of the TIN/NPIs be sampled with a minimum sample of 10 TIN/NPIs or a maximum sample of 50 TIN/NPIs. For each TIN/NPI sampled, it is encouraged that 25% of the TIN/NPI’s patients (with a minimum sample of 5 patients or a maximum sample of 50 patients) should be reviewed for all measures applicable to the patient.

• Define a process for completing a detailed audit if the qualified registry’s validation reveals inaccuracy and describe how this information will be conveyed to CMS.

QCDRs must perform the validation outlined in the validation strategy and send evidence of successful results to CMS for data collected in the reporting periods occurring in 2016 by June 30, 2016.

Submission of Quality Measures Data for Group Practices.
Responding to a mandate authorized through MACRA, CMS proposed that QCDRs also have the ability to submit quality measures data for group practices.

Auditing of Entities Submitting PQRS Quality Measures Data. CMS proposed that, beginning in 2016, any vendor submitting quality measures data for the PQRS (e.g., entities participating the PQRS as a qualified registry, QCDR, direct EHR, or DSV) comply with the following requirements:

Submission of Quality Measures Data for Group Practices. Finalized as proposed.

Auditing of Entities Submitting PQRS Quality Measures Data. Despite some requests to allow vendors more time for this, CMS finalized its policy as proposed. Note that these requirements will apply to all vendors submitting PQRS data: qualified registries, QCDRs, direct EHR vendors, or data submission vendors (DSV).
The vendor makes available to CMS the contact information of each EP on behalf of whom it submits data.

- The vendor must retain all data submitted to CMS for the PQRS program for a minimum of seven years.

For 2016, 2017 and 2018, is an EP does not satisfactorily report data on quality measures for covered professional services for the quality reporting year, the fee schedule amount for services furnished by such professional during the payment year shall be equal to 98.0% of the fee schedule amount that would otherwise apply to such services.

Tables 27 and 28 (p. 787-789) summarize the criteria for satisfactory reporting in 2016. These finalized criteria are also described below.

### Criterion for Reporting Individual Quality Measures via Claims and Registry for Individual EPs

CMS did not propose any changes to current requirements.

CMS also did not propose any changes to the Measures Applicability Validation (MAV) process for claims and registry for the 2016 reporting period.

### Criterion for Reporting Individual Quality Measures via EHR for Individual EPs

CMS did not propose any changes to current requirements.

### Criterion for Reporting Individual Quality Measures via Registry for Individual EPs

CMS did not propose any changes to current requirements.

### Criterion for Reporting Individual Quality Measures via Claims and Registry for Individual EPs

CMS finalized its decision to maintain the following reporting requirements: For the applicable 12-month reporting period, the EP would report at least 9 measures, covering at least 3 of the NQS domains, OR, if less than 9 measures apply to the EP, report on each measure that is applicable, AND report each measure for at least 50% of the 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 must report on at least 1 measure contained in the PQRS cross-cutting measure set.

### Criterion for Reporting Individual Quality Measures via EHR for Individual EPs

CMS finalized its decision to maintain the following reporting requirements: EP must report at least 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.

### Criterion for Reporting Individual Quality Measures via Registry for Individual EPs

CMS finalized its decision to maintain the following reporting requirements: For the 12-month reporting period for the 2018 PQRS payment adjustment, the EP would report at least 1 measures group AND report each measures group for at least 20 patients, the majority (11 patients) of which would be required to be Medicare Part B FFS patients. Measures groups containing a measure with a 0% performance rate would not be counted.
<table>
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<tbody>
<tr>
<td>CMS proposed to require group practices of 25 or more EPs that register to participate via the GPRO Web Interface to also select a CMS-certified survey vendor to report CAHPS for PQRS. However, CMS proposed to exclude group practices that report measures using the qualified registry, EHR, and QCDR reporting mechanisms since these groups may be highly specialized or otherwise unable to report CAHPS for PQRS.</td>
<td>CMS did not propose any changes to current requirements.</td>
</tr>
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</table>

**Satisfactory Participation in a QCDR by Individual EPs.** CMS finalized its decision to maintain the following reporting requirements: EP must 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% 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 of the outcome measures and at least 1 of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety.

**Criteria for Satisfactory Reporting for Group Practices Participating in the GPRO.** CMS decided to modify this proposal due to concerns raised about the cost of administering the CAHPS for PQRS, especially for smaller practices, and the fact that CMS did not release the final list of vendors approved to administer the CAHPS for PQRS survey for the 2015 reporting period until after the GPRO registration period closed.

As such, for 2016, **CMS will allow all group practices to voluntarily elect to administer the CAHPS for PQRS survey.** CMS is also requiring that only 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. This cohort is already required to report CAHPS for PQRS.

Although CMS previously finalized a 12-month reporting period for the administration of the CAHPS for PQRS survey, it is not technically feasible for CMS to collect data for purposes of CAHPS for PQRS until the close of the GPRO election/registration period (which is June 30 of the reporting year). As such, the administration of the CAHPS for PQRS survey will only contain 6-months of data. CMS does not believe this significantly alters the administration of CAHPS for PQRS and believes that 6-months of data provides an adequate sample.

Additional details about CAHPS for PQRS, including how beneficiary samples are selected, can be found on p. 766. Here, CMS clarifies that for the CAHPS for PQRS survey to apply to a group practice, the group practice must have an applicable focal provider (i.e., the provider named in the survey provided the beneficiary with the plurality of the beneficiary’s primary care services delivered by the group practice), as well as meet the minimum beneficiary sample for the CAHPS for PQRS survey. Several specialty types are excluded from selection as focal provider such as anesthesiology, diagnostic radiology, chiropractic, podiatry, PT, OT, emergency medicine, and critical care.
Proposed Criteria for Reporting Via the GPRO Web Interface. CMS did not propose any changes to current requirements other than those related to CAHPS for PQRS discussed above. Similarly, CMS proposed to continue using the attribution methodology used for the VM for the GPRO web interface beneficiary assignment methodology for the 2018 PQRS payment adjustment and future years.

Hospitalists are also excluded from selection as a focal provider. A CMS clarifies that regardless of the number of EPs, some group practices may not have a sufficient number of assigned beneficiaries to participate in the CAHPS for PQRS survey.

Proposed Criteria for Reporting Via the GPRO Web Interface. CMS finalized these requirements mostly as proposed, accounting for the previously discussed modification. Therefore, for 2016:

- For group practices of 25-99 EPs that register to participate in the GPRO for the 12-month reporting period for 2016 using the Web Interface and for which the CAHPS for PQRS survey applies, administration of the CAHPS for PQRS survey will be OPTIONAL for 2016.
- For group practices of 25-99 who elect to administer the CAHPS for PQRS survey in conjunction with the Web Interface, the group practice must report all CAHPS for PQRS survey measures via a certified survey vendor. In addition, the group practice would 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 would report on 100% of assigned beneficiaries. A group practice would be required to report on at least 1 measure for which there is Medicare patient data.
- For group practices of 100 or more EPs who register for the GPRO Web Interface and to which the CAHPS for PQRS survey applies, the administration of the CAHPS for PQRS survey will be REQUIRED for 2016. The group practice would report all CAHPS for PQRS survey measures via a certified survey vendor. In addition, the Web Interface requirements described in the previous bullet would apply.
- For group practices of 100 or more EPs to which the CAHPS for PQRS survey DOES NOT apply, the Web Interface requirements described previously would apply.

CMS will continue to rely on the attribution methodology used for the VM as the Web Interface beneficiary assignment methodology.
| Criteria for Reporting on Individual Measures for Group Practices Registered to Participate in the GPRO via Registry. CMS did not propose any major changes to current requirements. | CMS made a slight change to its proposal to reflect the fact that CAHPS for PQRS is now optional for groups with 2-99 EPs. If reporting via registry, **group practices with 2-99 EPs** may meet the criteria for satisfactory reporting for the 2018 PQRS payment adjustment in one of two ways:  
- **OPTION 1** (group practices that do not voluntarily elect to administer the CAHPS for PQRS survey in conjunction with the registry): Report at least 9 measures, covering at least 3 of the NQS domains. Of these measures, if a group practice has an EP that 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 the group practice reports on less than 9 measures covering at least 3 NQS domains, the group practice would report on each measure that is applicable to the group practice, AND report each measure for at least 50% of the EP’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.  
- **OPTION 2** (group practices that voluntarily elect to administer the CAHPS for PQRS survey in conjunction with the registry): Report all CAHPS for PQRS survey measures via a 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 and including at least 1 cross-cutting measure 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. |  
<table>
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<tbody>
<tr>
<td>Criteria for Reporting on Individual Measures for Group Practices Registered to Participate in the GPRO via EHR. CMS did not propose any changes to current requirements.</td>
<td>For <strong>group practices with 100+ EPs</strong> reporting via a qualified registry, the administration of the CAHPS for PQRS survey is REQUIRED. Therefore, these groups must report all CAHPS for PQRS survey measures via a 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 and at least 1 cross-cutting measure 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.</td>
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</table>
OPTIONAL in 2016 for group practices of 2-99 EPs, the following options are available:

- **OPTION 1** (group practices that do not voluntarily elect to administer the CAHPS for PQRS survey in conjunction with EHR): The group practice would 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.

- **OPTION 2** (group practices that voluntarily elect to administer the CAHPS for PQRS survey in conjunction with EHR): Report all CAHPS for PQRS survey measures via a 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 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 applicable measures. A group practice would be required to report on at least 1 measure for which there is Medicare patient data.

For **group practices with 100+ EPs** reporting via an EHR, the administration of the CAHPS for PQRS survey is REQUIRED. Therefore, these groups must report all CAHPS for PQRS survey measures via a 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 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 applicable measures. The group practice must report on at least 1 measure for which there is Medicare patient data.

Satisfactory Participation in a QCDR for Group Practices Registered to Participate in the GPRO via a QCDR. For purposes of the 2018 PQRS payment adjustment, CMS proposed to base it on data reported during the 12-month period in 2016 and to use the same existing reporting criteria that apply to individuals reporting via QCDRs.

Satisfactory Participation in a QCDR for Group Practices Registered to Participate in the GPRO via a QCDR. Consistent with other reporting mechanisms, CMS finalized a 12-month reporting period for this newly authorized reporting mechanism.

CMS finalized it proposal to apply the same criteria as it applies to individuals reporting via QCDR. Thus, the group practice must 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% 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.

Selection of PQRS Quality Measures for 2016 and Beyond (p. 790)

Table 43 on pgs. 870-913 lists ALL finalized individual PQRS quality measures and those included in measures groups reportable via claims, registry or EHR beginning in 2016.

Cross-Cutting Measures for 2016 Reporting and Beyond.

CMS finalized the addition of all four newly proposed cross-cutting measures for 2016 and beyond. These measures, which will be added to the current set of 19 cross-cutting measures, are listed in Table 29 on p. 798 and include:

- 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
- Breast Cancer Screening: Percentage of women 50 through 74 years of age who had a mammogram to screen for breast cancer within 27 months
- 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
- Falls: Plan of Care: Percentage of patients aged 65 years and older with a history of falls who had a care plan for falls documented within 12 months.

New PQRS Measures Available for Reporting for 2016 and Beyond and Changes to Existing PQRS Measures.

New PQRS Measures Available for Reporting for 2016 and Beyond and Changes to Existing PQRS Measures. Table 30 of the final rule (p. 800-835) contains additional measures that CMS proposed to include in the PQRS measure set for 2016 and beyond. Measures finalized as proposed or with modifications are listed on pgs. 800-829. Measures NOT finalized as proposed are listed on pgs. 829-835 and include:

- Cognitive Impairment Assessment Among At-Risk Older Adults
- Coordinating Care – Emergency Department Referrals
- Documentation of a Health Care Proxy for Patients with Cognitive Impairment: Extravasation of Contrast Following Contrast-Enhanced CT
- Frequency of Inadequate Bowel Preparation
- HIV: Ever Screened for HIV
HIV Screening of STI patients

In Table 30, CMS also indicates the PQRS reporting mechanism(s) through which each measure each reportable, as well as the Measures Application Partnership’s (MAP) recommendation regarding the measure. Note that in some cases, CMS did not adhere to the MAP’s final recommendation.

Domain changes. In Table 31, on pgs. 836-837, CMS provides its proposals and finalized policies for NQS domain changes for measures that are currently available for reporting under the PQRS. CMS finalized all domain changes as proposed.

Measures Proposed for Removal from the 2016 PQRS. In Table 32, on pgs. 838-845, CMS lists finalized policies regarding measures proposed for removal from the 2016 PQRS. All measures proposed for removal were finalized, except two maternity care measures. These include:

- Dementia: Screening for Depressive Symptoms
- Optimal Vascular Composite
- Oncology: Cancer Stage Documented
- Perioperative Temperature Management
- Preventive Care and Screening: Unhealthy Alcohol Use – Screening: (removed because it’s being replaced with Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling)
- Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older
- Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge

Proposed Changes to Reporting Mechanisms for Select Measures Beginning in 2016. Table 26, starting on p. 482, summarizes proposed changes to reporting mechanisms for select measures. In addition to multiple diabetes, CABG measures, and breast surgery measures, this list includes:

- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic [proposed for inclusion in the Cardiovascular Prevention measures group]
- Controlling High Blood Pressure [proposed for inclusion in the Cardiovascular Prevention measures group]
- Use of High-Risk Medications in the Elderly [proposed for inclusion in the Multiple Chronic Conditions Measures Group]

Changes to Reporting Mechanisms for Select Measures Beginning in 2016. In Table 33, pgs. 845-853, are finalized changes to reporting mechanisms for select measures in 2016. CMS finalized all of its proposed changes here.
• Coronary Artery Disease (CAD): Symptom Management [proposes to make this individual measure reportable via the CAD measures group only]
• Tuberculosis Prevention for Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier [proposed for inclusion in the Rheumatoid Arthritis Measures Group]
• Depression Remission at Twelve Months [proposes to add “registry” as a reporting option; CMS had intended to do this in 2015, but mistakenly never proposed it in the 2015 NPRM].

Measures Groups. CMS proposed to add 3 new measures groups for 2016:
• Cardiovascular Prevention (Million Hearts)
• Diabetic Retinopathy
• Multiple Chronic Conditions

CMS also proposed to amend the following previously finalized measures groups for reporting in the PQRS beginning in 2016:
• CABG measures group
• Dementia measures group: CMS proposes to add PQRS# 134 Preventive Care and Screening and delete PQRS #285 Dementia: Screening for Depressive Symptoms
• Diabetes measures group: CMS proposes to add PQRS #126 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy and delete PQRS #163 Diabetes: Foot Exam
• Preventive Care measures group: CMS proposes to add NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling and delete PQRS #173 Preventive Care and Screening: Unhealthy Alcohol Use – Screening
• Rheumatoid Arthritis measures group: CMS proposes to add PQRS #337 Tuberculosis Prevention for Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier.

Measures Available for Reporting in the GPRO Web Interface. CMS proposes to add one measure to the GPRO Web Interface beginning in 2016, which is Statin Therapy for the Prevention and Treatment of Cardiovascular Disease.

Measures Groups. CMS finalized the addition of all 3 proposed new measures groups for 2016. They are listed in Tables 34-36 on pgs. 856-858.

CMS also finalized its proposed changes to existing groups.
• Table 37 on p. 859 lists the CABG measures group.
• Table 38 on p. 861 lists the modified Dementia measures group.
• Table 39 on p. 863 lists the DM measures group.
• Table 40 on p. 864 lists the Preventive Care measures group.
• Table 41 on p. 866 lists the Rheumatoid Arthritis measures group.

Measures Available for Reporting in the GPRO Web Interface. CMS finalized its decision to add the Statin Therapy measure to the GPRO Web Interface. This measure is also reportable via a measures group (Cardiovascular Prevention) and registry in 2016. It will also be added to the Medicare Shared Savings Program starting in 2016. This measure is listed in Table 42 on p. 869.
### Certification Requirements for Reporting Electronic Clinical Quality Measures (eCQMs) in the EHR Incentive Program and PQRS (p. 917)

To allow providers to upgrade to 2015 Edition CEHRT before 2018, CMS proposed to revise the CEHRT definition for 2015 through 2017 to require that EHR technology is certified to report CQMs, in accordance with the optional certification, in the format that CMS can electronically accept if certifying to the 2015 Edition “CQMs – report” certification criterion. CMS also proposed to revise the CEHRT definition for 2018 and subsequent years to require that EHR technology is certified to report CQMs, in accordance with the optional certification, in the format that CMS can electronically accept.

CMS finalized these policies.

### MACRA Implementation (p. 914)

#### Request for input on the Provisions Included in MACRA (p. 914)

<table>
<thead>
<tr>
<th>Merit-Based Payment Incentive System (MIPS)</th>
<th>CMS sought input on:</th>
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<tbody>
<tr>
<td></td>
<td>• What would be an appropriate low-volume threshold for purposes of excluding certain eligible professionals from the definition of a MIPS eligible professional.</td>
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<tr>
<td></td>
<td>• Whether CMS should consider establishing a low-volume threshold using more than one or a combination of factors or, alternatively.</td>
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<td>• Whether CMS should focus on establishing a low-volume threshold based on one factor.</td>
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<td></td>
<td>• Which factors to include, individually or in combination, in determining a low-volume threshold.</td>
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<td></td>
<td>• Whether a low-volume threshold similar to ones currently used in other CMS reporting programs would be an appropriate low-volume threshold for the MIPS and the applicability of existing low-volume thresholds used in other CMS reporting programs toward MIPS.</td>
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<td>• What activities could be classified as clinical practice improvement activities.</td>
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CMS received over 90 “insightful and informative public comments,” which it will consider in its RFI and for future rulemaking.

#### Alternative Payment Models (APMs):

CMS sought broad comments on this topic.

Again, CMS received over 90 “insightful and informative public comments,” which it will consider in its RFI and for future rulemaking.
## Comprehensive Primary Care Initiative (p. 921)

| **EHR Incentive Program-Comprehensive Primary Care (CPC) Initiative Aligned Reporting (p. 921)** | For 2016, CMS proposed to require CPC practice sites to submit at least 9 CPC CQMs that cover 3 domains (rather than the current requirement of 2 domains). CMS proposed that for 2016, EPs who are part of CPC practice site and are in their first year of demonstrating meaningful use may also use this CPC group reporting option to report their CQMs electronically instead of reporting CQMs by attestation through the EHR Incentive Program’s Registration and Attestation System. CMS finalized these policies as proposed. However, note that EPs who choose this CPC group reporting option must use a reporting period for CQMs of one full year (not 90 days). Since the recently finalized Stage 3/Modifications to Meaningful Use in 2015 through 2017 final rule finalized a 90-day continuous EHR reporting period for new participants in 2016, EPs who are demonstrating meaningful use for the first time in 2016 and report CQMs through the CPC group reporting option must also successfully report CQMs by attestation through the EHR Incentive Program’s Registration and Attestation System for a 90-day reporting period in 2016 by October 1, 2016, or apply for a significant hardship exception from the 2017 payment adjustment. |
| **Public Comments Received on the Potential Expansion of the CPC Initiative (p. 926)** | Through 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. In the proposed rule, CMS sought comment on the potential future expansion of this program, including interaction with the chronic care management code. CMS received over 90 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, beneficiary cost-sharing, care management, further testing of the CPC initiative, eligibility for incentive payments for participation in Alternative Payment Models under MACRA, auditing requirements, aggregation of payer and clinical data, and engagement with providers across the broader medical neighborhood. It will consider these comments if the initiative is expanded through future rulemaking. |

## Medicare Shared Savings Program (p. 929)

| **Quality measures and performance standards** | CMS proposed to add a new Statin Therapy for the Prevention and Treatment of Cardiovascular Disease measure, developed by CMS in collaboration with other federal agencies and the Million Hearts® Initiative, to the Shared Savings Program. CMS finalized its decision to add the Statin Therapy measure to the MSSP ACO measure set. As such, the total measures in the MSSP measure set reported by ACOs will increase from 33 measures to 34 measures. Table 44 on p. 938 provides a summary of the number of measures by domain and the total points and domain weights that would be used for scoring purposes with the Statin Therapy measure added to the Preventive Health domain. Table 45 on pgs. 942-942 lists the finalized measures for use in establishing quality performance standards that ACOs must meet for shared savings. |
### Maintaining measures as pay-for-reporting when evidence changes

If a guideline update was published during a reporting year and the measure owner determined the measure specifications do not align with the updated clinical practice, CMS proposed to maintain the right to maintain a measure as pay-for-reporting (or revert a pay-for-performance measure to pay for reporting).

CMS also finalized its proposal to 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 practice due to clinical guideline changes or clinical evidence suggesting that the continued 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, and will offer the public an opportunity to comment.

### Assignment of Beneficiaries Based on Certain Evaluation and Management Services in Skilled Nursing Facilities

CMS proposed a revision to its current list of codes that constitute primary care services under the Shared Savings Program.

CMS also finalized its proposal to exclude from its definition of primary care services claims billed under CPT codes 99304 through 99318 when the claim includes the POS code 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. The current definition will be in use for the 2016 performance year. The new definition of primary care services, which excludes services furnished in SNFs from the definition of primary care services, will be effective starting with the 2017 performance year.

### Assignment of Beneficiaries to ACOs that Include ETA Hospitals

CMS proposed to consider HCPCS code G0463 when submitted by ETA hospitals as a primary care service for purposes of the Shared Savings Program.

CMS finalized this proposal.

### Value-Based Payment Modifier (VM) (p. 962)

Beginning with the 2016 payment adjustment period, CMS proposed that a TIN’s size would be determined based on the lower of the number of EPs indicated by the PECOS-generated list or CMS’ analysis of the claims data for purposes of determining the payment adjustment amount under the VM.

CMS finalized this policy as proposed.
For the 2018 payment adjustment period, CMS proposed to apply the VM to non-physician EPs who are physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs) in groups and those who are solo practitioners, and NOT to other types of professionals who are non-physician EPs. CMS had previously finalized that all non-physician EPs would be subject to the VM beginning with the 2018 payment adjustment. However, CMS proposed to modify this policy to account for the fact that the Merit-Based Payment Incentive System (MIPS), authorized under MACRA, will only apply to physicians, PAs, NPs, CNSs and CRNAs in the early years and will not apply to other non-physician EPs until the 2021 payment year.

CMS finalized this policy as proposed. Thus, CMS will apply the VM in 2018 to the items and services billed under the PFS by all of the physicians, PAs, NPs, CNSs, and CRNAs who bill under a group’s TIN based on the TIN’s performance during the applicable performance period.

The 2018 VM will NOT apply to other types of non-physician EPs (i.e., EPs who are not PAs, NPs, CNSs, or CRNAs) who may also bill under the TIN. [Note that these “other” non-physician EPs are still subject to the reporting requirements under the PQRS for 2016].

Also, PAs, NPs, CNSs, and CRNAs in groups that consist only of non-physician EPs, as well as PAs, NPs, CNSs, and CRNAs who are solo practitioners will be held harmless from downward adjustments under the quality-tiering methodology in 2018.

Under current policy, CMS relies on a two-category approach to determine whether and how the VM applies based on participation in the PQRS by groups and solo practitioners. CMS proposed to use a similar two-category approach for the 2018 VM based on participation in the PQRS by groups and solo practitioners. However, CMS proposed a slight modification to this policy. Under current policy, when determining who falls under Category 1, CMS only considers whether at least 50% of a group’s EPs met the criteria to avoid the PQRS payment adjustment as individuals if the group did not register to participate in the PQRS GPRO. In contrast, for the 2018 VM, CMS would consider whether the 50% threshold has been met regardless of whether the group registers for PQRS GPRO. This would allow groups that register for PQRS GPRO, but fail as a group to meet the reporting criteria, an additional opportunity for the quality data reported by individual EPs in the group to be taken into account for purposes of the VM. If operationally feasible, CMS proposed to also apply this revised criteria to the 2017 VM.

CMS also determined that it is operationally feasible to begin applying this revised criteria to the 2017 VM.

CMS finalized these policies as proposed.

CMS also proposed a new policy to address the circumstance in which a group is initially determined not to have met the criteria to avoid the PQRS payment adjustment and subsequently, through the informal review process, at least 50% of its EPs are determined to have met the criteria to avoid the PQRS payment adjustment as individuals. CMS proposed to reclassify a TIN as Category 1 when PQRS determines, upon informal review, that at least 50% of the TIN’s EPs met the criteria for satisfactory reporting of data on PQRS...
Application of the VM to Groups and Solo Practitioners who Participate in Multiple Shared Savings Program ACOs. To address the small number of TINs that are ACO participants in multiple ACOs, CMS proposed, beginning with the 2017 payment adjustment period, to apply the VM adjustment percentage based on the performance of the ACO with the highest quality composite score.

Application of VM to Participant TINs in Shared Savings Program ACOs that also include EPs who participate in Innovation Center Models. Beginning with the 2017 payment adjustment period, CMS proposed to apply the VM for groups and solo practitioners that participated in an ACO under the Shared Savings Program, regardless of whether any EPs in the group or the solo practitioner also participated in an Innovation Center model during the performance period.

Application of VM to Participant TINs in Shared Savings Program ACOs that Do Not Complete Quality Reporting. For the 2018 VM payment adjustment, CMS proposed to continue its policy that if an ACO does not successfully report quality data as required by the Shared Savings Program, all groups and solo practitioners participating in the ACO will fall in Category 2 for the VM and will be subject to a downward payment adjustment.

Application of an Additional Upward Payment Adjustment to High Quality Participant TINs in Shared Savings Program ACOs for Treating High-risk Beneficiaries. Beginning in the 2017 payment adjustment period, CMS proposed to continue its policy of applying an additional upward payment adjustment of +1.0x to Shared Savings ACO Program participant TINs that are classified as “high quality” under the quality-tiering methodology, if the ACOs in which the TINs participated during the performance period have an attributed patient population that 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.

Application of the VM to Physicians and Non-physician EPs that Participate in the Pioneer ACO Model, the CPC Initiative, or Other Similar Innovation Models. Beginning with the 2017 payment...
adjustment period, CMS proposed to continue its policy of waiving application of the VM for groups and solo practitioners, as identified by TIN, if at least one EP who billed for PFS items and services under the TIN during the applicable performance period for the VM participated in the Pioneer ACO Model, CPC Initiative, or other similar Innovation Center models-- including the Next Generation ACO Model, the Oncology Care Model, and the Comprehensive ESRD Care Initiative-- during the performance period.

<table>
<thead>
<tr>
<th>Payment Adjustment Amount (p. 987-996)</th>
<th>Quality Tiering: Upward Adjustments</th>
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<tbody>
<tr>
<td>CMS proposed to set the maximum upward adjustment under the quality-tiering methodology for the 2018 VM (based on 2016 reporting) to:</td>
<td>CMS finalized these policies as proposed despite concerns about its aggressive implementation plan and the burden they would pose for smaller practices. CMS believes that physicians have been given sufficient time and data with which to become familiar with the program.</td>
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<tr>
<td>• +4.0 times an upward payment adjustment factor (to be determined after the performance period has ended) for groups with 10 or more EPs;</td>
<td>Table 47 on p. 1021 shows the final 2018 VM quality-tiering payment adjustment amounts for physicians, PAs, NPs, CNSs, and CRNAs in groups of physicians with 10 or more EPs.</td>
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<tr>
<td>• +2.0 times an adjustment factor for groups with between 2 to 9 EPs and physician solo practitioners; and</td>
<td>Table 48 on p. 1021 shows the final 2018 VM quality-tiering payment adjustment amounts for physicians, PAs, NPs, CNSs, and CRNAs in groups of physicians with 2-9 EPs and physician solo practitioners.</td>
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<td>• +2.0 times an adjustment factor for groups and solo practitioners that consist of non-physician EPs who are PAs, NPs, CNSs, and CRNAs.</td>
<td>Table 48 on p. 1022 shows the final 2018 VM quality-tiering payment adjustment amounts for PAs, NPs, CNSs, and CRNAs in groups consisting of only non-physician EPs, as well as PAs, NPs, CNSs, and CRNAs who are solo practitioners.</td>
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<tr>
<th>Quality Tiering: Downward Adjustments</th>
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<tr>
<td>CMS proposed to set the amount of payment at risk under the 2018 VM (based on 2016 reporting) to:</td>
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<tr>
<td>• -4.0% for groups with 10 or more EPs;</td>
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<tr>
<td>• -2% for groups with between 2 to 9 EPs and physician solo practitioners; and</td>
</tr>
<tr>
<td>• -2% for groups and solo practitioners that consist of non-physician EPs who are PAs, NPs, CNSs, and CRNAs.</td>
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PAs, NPs, CNSs, and CRNAs in groups that consist of only non-physician EPs, as well as PAs, NPs, CNSs, and CRNAs who are solo practitioners will be held harmless from downward adjustments under the quality-tiering methodology in 2018. CMS will continue to provide an additional upward payment adjustment of +1.0x to groups and solo practitioners that have an average beneficiary risk score that is in the top 25 percent of all beneficiary risk scores.

In general, CMS noted that it works with medical and specialty associations and have National Provider Calls throughout the year to educate physicians and other professionals about the VM program and the QRURs. Further outreach also will be undertaken by its Quality Improvement Organizations (QIOs), which will provide technical assistance to physicians and groups of physicians in an effort to help them improve quality and consequently, performance under the VM program.

<table>
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<tr>
<th>Quality and Cost</th>
<th>CMS proposed no changes to the quality or cost measures currently used to calculate the VM other than to align the quality measures and quality reporting mechanisms for the 2018 VM with those</th>
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<tr>
<td>CMS finalized this policy.</td>
<td>With regard to commenters’ concern about lack of episode based cost</td>
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<td>Measures (p. 1027)</td>
<td>Measures available to groups and individuals under the PQRS during the 2016 performance period. Measures, CMS believes that the total per capita cost measure, condition-specific total per capita cost measures, and MSPB measure provide sufficient cost performance data for VM cost composite calculation and are inclusive of episode cost-based measures.</td>
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| Benchmarks for eCQMs (p. 1029) | CMS proposed to separately benchmark the PQRS eCQMs beginning with the 2016 performance period. Benchmarks would be calculated based on 2015 performance data. CMS finalized this policy as proposed. Several commenters asked for clarification on how benchmarks for quality of care measures reported via PQRS QCDRs will be calculated—i.e., whether QCDR measures would only be benchmarked against identical measures that are reported via a different QCDR or other reporting mechanism. Commenters also requested clarification on whether QCDRs will be allowed to develop their own benchmarking methodology or if CMS plans to calculate the benchmarks using its current methodology.

CMS clarified that PQRS measures reported via QCDRs will be benchmarked according to CMS’ current VM benchmarking methodology which is defined as follows:

*The benchmark for quality of care measures reported through the PQRS using the claims, registries, QCDR, or web interface is the national mean for that measure’s performance rate (regardless of the reporting mechanism) during the year prior to the performance period. Benchmarks for non-PQRS quality of care measures reported via QCDRs would also be calculated as the national mean of the measure’s performance rate across all EPs reporting the measure via different QCDRs during the year prior to the performance period.*

Note that measures reported through a QCDR that are new to PQRS would not be included in the quality composite for the VM because CMS would not be able to calculate benchmarks for them. |
| CAHPS Reporting (p. 1031) | CMS proposed to continue its policy of including CAHPS for PQRS data in a group’s quality composite score under the VM, should the group elect to do so. CMS also proposed to include CAHPS survey data in the quality composite for the VM for TINs participating in ACOs under the Shared Savings Program beginning with the 2016 performance period (i.e., 2018 payment). CMS finalized these two policies as proposed. |
### Expansion of the Informal Inquiry Process to Allow Corrections for the Value-Based Payment Modifier (p. 1034)

CMS previously finalized, beginning with the 2016 payment adjustment period, (1) a deadline of 60 days that would start after the release of the QRURs for a group or solo practitioner to request a correction of a perceived error related to the VM calculation, and (2) that it would take steps to establish a process for accepting requests from physicians to correct certain errors made by CMS or a third-party vendor (for example, PQRS-qualified registry). CMS noted that if the operational infrastructure was not available to allow for a recomputation, that it would continue its approach to classify a TIN as “average quality” in the event an error is detected in the calculation of the quality composite. CMS also finalized that it would recalculate the cost composite in the event that an error was made in the cost composite calculation and that it would provide additional operational details as necessary through sub-regulatory guidance. CMS proposed to continue these policies.

Several commenters cautioned against CMS’ over-reliance on the automatic “average quality” designation as it may not accurately reflect the quality of truly high performers and may penalize physicians for errors that are outside of their control. One commenter also suggested extending the review period to 90 days to give practitioners enough time to thoroughly review the QRURs.

Despite these concerns, CMS continues to believe that the “average” quality designation remains the best alternative and that the 60-day review period allows ample time for practitioners to access and review their QRURs. Therefore, it will maintain the 60-day review period and its policy of classifying a TIN as “average quality” in the event it determines a third-party vendor error or CMS made an error in the calculation of the quality composite and the infrastructure was not available to allow for recomputation of the quality measure data.

CMS also finalized its proposal to reclassify a TIN as Category 1 when PQRS determines on informal review that at least 50% of the TIN’s EPs meet the criteria to avoid the PQRS downward payment adjustment for the relevant payment adjustment year. If the group was initially classified as Category 2, then CMS would not expect to have data for calculating their quality composite, in which case they would be classified as “average quality.” However, if the data is available in a timely manner, then CMS would recalculate the quality composite.

### Minimum Episode Count for the Medicare Spending Per Beneficiary (MSPB) Measure (p. 1038)

Beginning with the 2017 payment adjustment period, CMS proposed to increase the minimum number of episodes for inclusion of the MSPB measure in the cost composite to 100 episodes, rather than 20.

Many commenters that supported this proposal also suggested that CMS consider an even higher minimum number of episodes (e.g., 200 episodes). A few commenters opposed the proposal and/or suggested a lower minimum number of episodes such as 50 due to concern over situations where a group that would have performed well on this measure would no longer have this measure included in its cost composite as a result of the proposal, which could negatively impact their cost composite score, and ultimately their VM adjustment.

Due to these and other concerns, CMS conducted a more granular reliability analysis and determined that a minimum of 125 episodes is preferable to the reliability associated with the other minimum numbers of episodes suggested by some commenters. CMS recognizes that establishing a higher case minimum will reduce the number of groups and solo practitioners for whom it will be able to include an MSPB calculation in the cost composite. However, CMS does not believe it should use the measure in calculating the cost composite if it is not reliable. Further, it believes that a minimum of 125...
episodes is preferable to a higher minimum, such as 200 episodes, which might slightly increase the reliability of the measure but would further reduce the number of groups and solo practitioners for whom CMS would be able to include an MSPB calculation in the cost composite.

As such, **CMS is finalized an episode minimum of 125 episodes for the MSPB measure beginning with the 2017 payment adjustment period/2015 performance period.**

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<tr>
<th>Inclusion of Maryland Hospital stays in definition of Index Admissions (p. 1042)</th>
<th>Beginning with the 2018 VM, CMS proposed to include inpatient hospitalizations at Maryland hospitals as an index admission for the MSPB measure for the purposes of the VM program. CMS finalized this policy.</th>
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<td>Average Quality Designations in Certain Circumstances (p. 1046)</td>
<td>Beginning with the 2016 payment adjustment, CMS proposed that a group or solo practitioner subject to the VM would receive a quality composite score that is classified as average under the quality-tiering methodology if the group or solo practitioner does not have at least one quality measure that meets the minimum number of cases required for the measure to be included in the calculation. CMS finalized this policy related to quality scores, as proposed, which is consistent with the policy it previously finalized that, beginning with the 2016 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 that meets the minimum number of cases required for the measure to be included in the calculation of the cost composite. A quality measure must have 20 or more cases to be included in the calculation of the quality composite. However, beginning with the 2017 payment adjustment period, as previously finalized, the all-cause hospital readmissions measure must have 200 or more cases to be included. CMS believes this policy is appropriate despite public concerns that some practices could be subject to a downward adjustment if classified as “average cost and low quality” or “average quality and high cost” and that for this reason, EPs that receive an automatic average designation due to a lack of either quality or cost measure data should be held harmless from any downward payment adjustment under the VM. In its analysis of groups that are subject to the 2016 VM, CMS found that no TIN received a downward adjustment under the quality-tiering methodology as a result of being classified as average quality and high cost under this policy. Its also found...</td>
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<td><strong>Technical Changes to the “Benchmarks for Cost measures” (p. 1048)</strong></td>
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<td>CMS clarifies here that for the 2015 VM, the peer group for calculating the benchmarks for cost measures was all groups of physicians to which beneficiaries are attributed and that are subject to the VM (e.g., for 2015, the cost measures of groups with 100 or more EPs was compared to the cost measures of other groups of 100 or more EPs). However, CMS subsequently finalized a policy to apply, beginning with the 2016 VM, a specialty adjustment that refines the peer group methodology by creating a standardized score for each group’s cost measures that accounts for specialty mix. CMS clarifies in this rule that this methodology creates one national benchmark for each cost measure against which all groups (regardless of size) are assessed.</td>
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<th><strong>Discussion of Stratification of Cost Measure Benchmarks by Beneficiary Risk Score (p. 1049)</strong></th>
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<td>In response to public concerns that the CMS-hierarchical condition categories (HCC) Risk Adjustment methodology used in the total per capita cost measures for the VM does not accurately capture the additional costs associated with treating the sickest beneficiaries, CMS solicited comments, but made no proposals, on stratifying cost measure benchmarks by beneficiary risk score. CMS notes that it continues to believe that its current methodology of using HCC scores that include adjustments for Medicare and Medicaid eligibility status in addition to diagnoses, and replacing the highest 1% of costs with the cost of the 99th percentile for the highest cost beneficiaries, help address public concerns. To address concerns regarding specialties that might routinely treat more complex and more costly beneficiaries, CMS reminds readers that it now applies a specialty adjustment to all cost measures used in the VM. In regards to its request for feedback of stratifying cost measure benchmarks by beneficiary risk score, nearly all commenters supported this concept and some suggested that CMS consider other concerns, such as how to distinguish between specialists and sub-specialists in the same field or between physicians with similar training but very different practice profiles such as primary care physicians who are office-based versus those who are largely providing care in a hospital, skilled nursing facility or patient’s home. CMS will continue to work with stakeholders to further explore options for risk stratified comparisons and present any proposed through future rulemaking.</td>
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<th><strong>Physician Feedback Program (p. 1051)</strong></th>
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<td><strong>2014 Quality and Resource Use Reports</strong></td>
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*Prepared by Hart Health Strategies, Inc. [www.hhs.com](http://www.hhs.com), November 2015*
| (QRURs) Based on CY 2014 Data and Disseminated in 2015 (p. 1051) | 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.

In response to stakeholder feedback to provide more timely and actionable information on outcomes and cost measures, CMS also provided for the first time a mid-year report, the 2014 Mid-Year QRUR (MYQRUR) in spring 2015. The 2014 MYQRUR was provided to physician solo practitioners and groups of physicians nationwide who billed for Medicare-covered services under a single TIN over the period of July 1, 2013, through June 30, 2014. CMS will disseminate Mid-Year QRURs in the spring of each year to provide interim information about performance only on those cost and quality outcomes measures that CMS calculates directly from Medicare administrative claims, based on the most recent 12 months of data that are available. The MYQRURs are for informational purposes and do not estimate performance for the calculation of the VM. Beginning in spring 2016, CMS intends to expand the distribution of MYQRURs to non-physician EPs, solo practitioners, and groups composed of non-physician EPs.

Commenters continue to have concerns about timeliness of reports; the accessibility of the reports; the complexity of the reports, and the outreach regarding the VM program. CMS acknowledges that the QRUR reports could be perceived as complex, but believes they contain a significant amount of valuable data to help EPs understand and improve the quality and efficiency of their care. CMS remind the public that it has added a performance dashboard to provide a visual snapshot and summary of performance to the beginning of the reports. The agency encourages all EPs to access their report and to submit feedback to the PV helpdesk at 1-888-734-6433 (select option 3) or at pvhelpdesk@cms.hhs.gov.

CMS disagrees that it does not provide adequate outreach about the VM. It reminds the public that it conducts National Provider Calls in conjunction with each QRUR release, and provides education and outreach documents on its website related to the VM, how to access the QRURs, and how to interpret the QRURs. CMS will continue to engage the stakeholder community to determine how best to educate about value-based payment programs.

| Episode Costs and Supplemental | In summer 2014, CMS distributed the Supplemental QRUR: Episodes of Care based on 2012 data to groups with 100 or more EPs. These 2012 Supplemental QRURs provided information on 20 episode subtypes and 6 clinical episode-based measures.

In fall 2015, CMS provided the 2014 Supplemental QRURs to all groups and solo practitioners nationwide who billed for |
Medicare-covered services under a single TIN in 2014 and for whom CMS was able to calculate at least one episode measure. The 2014 Supplemental QRURs included 26 major episode measures and 38 sub types of episodes and were made available to over 300,000 groups and solo practitioners.

These reports provide performance on episode-based cost measures that are not included in the VM, to help groups and solo practitioners understand the cost of care they provide to beneficiaries and work toward the provision of more efficient care. CMS will continue to seek stakeholder input as it develops the episode framework.