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Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 405, 410, et al.

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 405, 410, 411, 412, 413, 414, 425, 489, 495, and 498

[CMS–1612–FC]

RIN 0938–AS12

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule with comment period.

SUMMARY: This major final rule with comment period addresses changes to the physician fee schedule, and other Medicare Part B payment policies to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services, as well as changes in the statute. See the Table of Contents for a listing of the specific issues addressed in this rule.

DATES: *Effective date:* The provisions of this final rule are effective on January 1, 2015, with the exception of amendments to parts 412, 413, and 495 which are effective October 31, 2014.

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on December 30, 2014.

Compliance date: The compliance date for new data collection requirements in § 403.904(c)(8) is January 1, 2016.

ADDRESSES: In commenting, please refer to file code CMS–1612–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *www.regulations.gov*. Follow the instructions for ''submitting a comment.''

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1612–FC, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1612–FC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

FOR FURTHER INFORMATION CONTACT: Donta Henson, (410) 786–1947 for any physician payment issues not identified below.

Gail Addis, (410) 786–4522, for issues related to the refinement panel.

Chava Sheffield, (410) 786–2298, for issues related to practice expense methodology, impacts, the sustainable growth rate, conscious sedation, or conversion factors.

Kathy Kersell, (410) 786–2033, for issues related to direct practice expense inputs.

Jessica Bruton, (410) 786–5991, for issues related to potentially misvalued services or work RVUs.

Craig Dobyski, (410) 786–4584, for issues related to geographic practice cost indices or malpractice RVUs.

Ken Marsalek, (410) 786–4502, for issues related to telehealth services.

Pam West, (410) 786–2302, for issues related to conditions for therapists in private practice or therapy caps.

Ann Marshall, (410) 786–3059, for issues related to chronic care management.

Marianne Myers, (410) 786–5962, for issues related to ambulance extender provisions.

Amy Gruber, (410) 786–1542, for issues related to changes in geographic area designations for ambulance payment.

Anne Tayloe-Hauswald, (410) 786–4546, for issues related to clinical lab fee schedule.

Corinne Axelrod, (410) 786–5620, for issues related to Rural Health Clinics or Federally Qualified Health Centers.

Renee Mentnech, (410) 786–6692, for issues related to access to identifiable data for the Centers for Medicare & Medicaid models.

Marie Casey, (410) 786–7861 or Karen Reinhardt, (410) 786–0189, for issues related to local coverage determination process for clinical diagnostic laboratory tests.

Frederick Grabau, (410) 786–0206, for issues related to private contracting/opt-out.

David Walczak, (410) 786–4475, for issues related to payment policy for substitute physician billing arrangements (locum tenens).

Melissa Heesters, (410) 786–0618, for issues related to reports of payments or other transfers of value to covered recipients.

Alesia Hovatter, (410) 786–6861, for issues related to physician compare.

Christine Estella, (410) 786–0485, for issues related to the physician quality reporting system.

Alexandra Mugge, (410) 786–4457, for issues related to EHR incentive program.

Patrice Holtz, (410) 786–5663, for issues related to comprehensive primary care initiative.

Terri Postma, (410) 786–4169, for issues related to Medicare Shared Savings Program.

Kimberly Spalding Bush, (410) 786–3232, for issues related to value-based modifier and improvements to physician feedback.

Elizabeth Holland, (410) 786–1309, Medicare EHR Incentive Program (Medicare payment adjustments and hardship exceptions).

Elisabeth Myers (CMS), (410) 786–4751, Medicare EHR Incentive Program (Medicare payment adjustments and hardship exceptions).

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of

these shares are proxies for the work, PE, and malpractice RVUs for anesthesia services. Information regarding the anesthesia work, PE, and malpractice shares can be found at the following: *https://www.cms.gov/center/anesth.asp*.

The anesthesia CF in effect in CY 2014 is $22.6765. Section 101 of PAMA provides for a 0.0 percent update from January 1, 2015 through March 31, 2015. After applying the 0.9994 budget neutrality factor described above, the anesthesia CF in effect from January 1, 2015 through March 31, 2015 will be $22.5550.

The table below includes adjustments to the anesthesia CF that are analogous to the physician fee schedule CF with other adjustments that are specific to anesthesia. In order to calculate the CY 2015 anesthesia CF for April 1, 2015 through December 31, 2015, the statute requires us to calculate the CFs for all previous years as if the various legislative changes to the CFs for those years had not occurred. The resulting CF is then adjusted for the update (the MEI, less multi-factor productivity and increased by the UAF). The national average CF is then adjusted for anesthesia specific work, practice expense and malpractice factors that must be applied to the anesthesia CF as the anesthesia fee schedule does not have RVUs. Accordingly, under current law, the anesthesia CF in effect in CY 2015 for the time period from April 1, 2015 through December 31, 2015 is $17.7913. We illustrate the calculation of the CY 2015 anesthesia CFs in Table 45.

TABLE 46—CALCULATION OF THE CY 2015 ANESTHESIA CF

January 1, 2015 through March 31, 2015		
CY 2014 National Average Anesthesia CF		$22.6765
Update	0.0 percent (1.00)	
CY 2015 RVU Budget Neutrality Adjustment	0.0006 percent (0.9994)	
CY 2015 Anesthesia Fee Schedule Practice Expense Adjustment	0.005 percent (.99524)	
CY 2015 National Average Anesthesia CF (1/1/2015 through 3/31/2015)		$22.5550
April 1, 2015 through December 31, 2015		
2014 National Average Anesthesia Conversion Factor in effect in CY 2015		$22.6765
2014 National Anesthesia Conversion Factor had Statutory Increases Not Applied		$17.2283
CY 2015 Medicare Economic Index	0.8 percent (1.008)	
CY 2015 Update Adjustment Factor	3.0 percent (0.9994)	
CY 2015 Budget Neutrality Work and Malpractice Adjustment	−0.06 percent (0.9994)	
CY 2015 Anesthesia Fee Schedule Practice Expense Adjustment	0.005 percent (.99524)	
CY 2015 Anesthesia Conversion Factor (4/1/2015 through 12/31/2015)		$17.7913
Percent Change from 2014 to 2015 (4/1/2015 through 12/31/2015)		−21.5%

III. Other Provisions of the Final Rule With Comment Period Regulation

A. Ambulance Extender Provisions

1. Amendment to Section 1834(l)(13) of the Act

Section 146(a) of the MIPPA amended section 1834(l)(13)(A) of the Act to specify that, effective for ground ambulance services furnished on or after July 1, 2008 and before January 1, 2010, the ambulance fee schedule amounts for ground ambulance services shall be increased as follows:

- For covered ground ambulance transports that originate in a rural area or in a rural census tract of a metropolitan statistical area, the fee schedule amounts shall be increased by 3 percent.
- For covered ground ambulance transports that do not originate in a rural area or in a rural census tract of a metropolitan statistical area, the fee schedule amounts shall be increased by 2 percent.

The payment add-ons under section 1834(l)(13)(A) of the Act have been extended several times. Recently, section 1104(a) of the Pathway for SGR Reform Act of 2013, enacted on December 26, 2013, as Division B (Medicare and Other Health Provisions) of Pub L. 113–67, amended section 1834(l)(13)(A) of the Act to extend the payment add-ons described above through March 31, 2014. Subsequently, section 104(a) of the Protecting Access to Medicare Act of 2014 (Pub. L. 113–93, enacted on April 1, 2014) amended section 1834(l)(13)(A) of the Act to extend the payment add-ons again through March 31, 2015. Thus, these payment add-ons also apply to covered ground ambulance transports furnished before April 1, 2015. (For a discussion of past legislation extending section 1834(l)(13) of the Act, please see the CY 2014 PFS final rule (78 FR 74438 through 74439)).

These statutory requirements are self-implementing. A plain reading of the statute requires only a ministerial application of the mandated rate increase, and does not require any substantive exercise of discretion on the part of the Secretary. In the CY 2015 PFS proposed rule (79 FR 40372), we proposed to revise § 414.610(c)(1)(ii) to conform the regulations to these statutory requirements. We received one comment regarding this proposal. A summary of the comment we received and our response are set forth below.

Comment: One commenter supported the implementation of the ambulance payment add-ons. The commenter also agreed that these provisions are self-implementing.

Response: We thank the commenter for their support of these provisions.

After consideration of the public comment received, we are finalizing our proposal to revise § 414.610(c)(1)(ii) to conform the regulations to these statutory requirements.

2. Amendment to Section 1834(l)(12) of the Act

Section 414(c) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108–173, enacted on December 8, 2003) (MMA) added section 1834(l)(12) to the Act, which specified that in the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2010, for which transportation originates in a qualified rural area (as described in the statute), the Secretary shall provide for a percent increase in the base rate of the fee schedule for such transports. The statute requires this percent increase to be based on the Secretary's estimate of the average cost per trip for such services (not taking into account mileage) in the lowest quartile of all rural county populations as compared to the average cost per trip

for such services (not taking into account mileage) in the highest quartile of rural county populations. Using the methodology specified in the July 1, 2004 interim final rule (69 FR 40288), we determined that this percent increase was equal to 22.6 percent. As required by the MMA, this payment increase was applied to ground ambulance transports that originated in a ''qualified rural area''; that is, to transports that originated in a rural area included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density. For this purpose, rural areas included Goldsmith areas (a type of rural census tract). This rural bonus is sometimes referred to as the ''Super Rural Bonus'' and the qualified rural areas (also known as ''super rural'' areas) are identified during the claims adjudicative process via the use of a data field included on the CMS-supplied ZIP code File.

The Super Rural Bonus under section 1834(l)(12) of the Act has been extended several times. Recently, section 1104(b) of the Pathway for SGR Reform Act of 2013, enacted on December 26, 2013, as Division B (Medicare and Other Health Provisions) of Pub. L. 113–67, amended section 1834(l)(12)(A) of the Act to extend this rural bonus through March 31, 2014. Subsequently, section 104(b) of the Protecting Access to Medicare Act of 2014 (Pub. L. 113–93, enacted on April 1, 2014) amended section 1834(l)(12)(A) of the Act to extend this rural bonus again through March 31, 2015. Therefore, we are continuing to apply the 22.6 percent rural bonus described above (in the same manner as in previous years) to ground ambulance services with dates of service before April 1, 2015 where transportation originates in a qualified rural area. (For a discussion of past legislation extending section 1834(l)(12) of the Act, please see the CY 2014 PFS final rule (78 FR 74439 through 74440)).

These statutory provisions are self-implementing. Together, these statutory provisions require a 15-month extension of this rural bonus (which was previously established by the Secretary) through March 31, 2015, and do not require any substantive exercise of discretion on the part of the Secretary. In the CY 2015 PFS proposed rule (79 FR 40372), we proposed to revise § 414.610(c)(5)(ii) to conform the regulations to these statutory requirements. We received one comment regarding this proposal. A summary of the comment we received and our response are set forth below.

Comment: One commenter supported the implementation of the percent increase in the base rate of the fee schedule for transports in areas defined as super rural. The commenter also agreed with CMS that these provisions are self-implementing.

Response: We thank the commenter for their support of these provisions.

After consideration of the public comment received, we are finalizing our proposal to revise § 414.610(c)(5)(ii) to conform the regulations to these statutory requirements.

B. Changes in Geographic Area Delineations for Ambulance Payment

1. Background

Under the ambulance fee schedule, the Medicare program pays for ambulance transportation services for Medicare beneficiaries when other means of transportation are contraindicated by the beneficiary's medical condition, and all other coverage requirements are met. Ambulance services are classified into different levels of ground (including water) and air ambulance services based on the medically necessary treatment provided during transport.

These services include the following levels of service:

- For Ground—
  - ++ Basic Life Support (BLS) (emergency and non-emergency)
  - ++ Advanced Life Support, Level 1 (ALS1) (emergency and non-emergency)
  - ++ Advanced Life Support, Level 2 (ALS2)
  - ++ Paramedic ALS Intercept (PI)
  - ++ Specialty Care Transport (SCT)
- For Air—
  - ++ Fixed Wing Air Ambulance (FW)
  - ++ Rotary Wing Air Ambulance (RW)

a. Statutory Coverage of Ambulance Services

Under sections 1834(l) and 1861(s)(7) of the Act, Medicare Part B (Supplemental Medical Insurance) covers and pays for ambulance services, to the extent prescribed in regulations, when the use of other methods of transportation would be contraindicated by the beneficiary's medical condition.

The House Ways and Means Committee and Senate Finance Committee Reports that accompanied the 1965 Social Security Amendments suggest that the Congress intended that—

- The ambulance benefit cover transportation services only if other means of transportation are contraindicated by the beneficiary's medical condition; and
- Only ambulance service to local facilities be covered unless necessary services are not available locally, in which case, transportation to the nearest facility furnishing those services is covered (H.R. Rep. No. 213, 89th Cong., 1st Sess. 37 and Rep. No. 404, 89th Cong., 1st Sess. Pt 1, 43 (1965)).

The reports indicate that transportation may also be provided from one hospital to another, to the beneficiary's home, or to an extended care facility.

b. Medicare Regulations for Ambulance Services

Our regulations relating to ambulance services are set forth at 42 CFR part 410, subpart B and 42 CFR part 414, subpart H. Section 410.10(i) lists ambulance services as one of the covered medical and other health services under Medicare Part B. Therefore, ambulance services are subject to basic conditions and limitations set forth at § 410.12 and to specific conditions and limitations included at § 410.40 and § 410.41. Part 414, subpart H, describes how payment is made for ambulance services covered by Medicare.

2. Provisions of the Final Rule

Historically, the Medicare ambulance fee schedule has used the same geographic area designations as the acute care hospital inpatient prospective payment system (IPPS) and other Medicare payment systems to take into account appropriate urban and rural differences. This promotes consistency across the Medicare program, and it provides for use of consistent geographic standards for Medicare payment purposes.

The current geographic areas used under the ambulance fee schedule are based on OMB standards published on December 27, 2000 (65 FR 82228 through 82238), Census 2000 data, and Census Bureau population estimates for 2007 and 2008 (OMB Bulletin No. 10–02). For a discussion of OMB's delineation of Core-Based Statistical Areas (CBSAs) and our implementation of the CBSA definitions under the ambulance fee schedule, we refer readers to the preamble of the CY 2007 Ambulance Fee Schedule proposed rule (71 FR 30358 through 30361) and the CY 2007 PFS final rule (71 FR 69712 through 69716). On February 28, 2013, OMB issued OMB Bulletin No. 13–01, which established revised delineations for Metropolitan Statistical Areas (MSAs), Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas. A copy of this bulletin may be obtained at *http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf*. According to OMB, ''[t]his

bulletin provides the delineations of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the United States and Puerto Rico based on the standards published on June 28, 2010, in the **Federal Register** (75 FR 37246–37252) and Census Bureau data.'' OMB defines an MSA as a CBSA associated with at least one urbanized area that has a population of at least 50,000, and a Micropolitan Statistical Area (referred to in this discussion as a Micropolitan Area) as a CBSA associated with at least one urban cluster that has a population of at least 10,000 but less than 50,000 (75 FR 37252). Counties that do not qualify for inclusion in a CBSA are deemed ''Outside CBSAs.'' We note that, when referencing the new OMB geographic boundaries of statistical areas, we are using the term ''delineations'' consistent with OMB's use of the term (75 FR 37249).

Although the revisions OMB published on February 28, 2013 are not as sweeping as the changes made when we adopted the CBSA geographic designations for CY 2007, the February 28, 2013 OMB bulletin does contain a number of significant changes. For example, we stated in the CY 2015 PFS proposed rule (79 FR 40373) that if we adopt the revised OMB delineations, there would be new CBSAs, urban counties that would become rural, rural counties that would become urban, and existing CBSAs that would be split apart. We have reviewed our findings and impacts relating to the new OMB delineations, and find no compelling reason to further delay implementation. We stated in the proposed rule that we believe it is important for the ambulance fee schedule to use the latest labor market area delineations available as soon as reasonably possible to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts.

Additionally, in the FY 2015 IPPS proposed rule (79 FR 28055), we also proposed to adopt OMB's revised delineations to identify urban areas and rural areas for purposes of the IPPS wage index. This proposal was finalized in the FY 2015 IPPS final rule (79 FR 49952). For the reasons discussed above, we believe it would be appropriate to adopt the same geographic area delineations for use under the ambulance fee schedule as are used under the IPPS and other Medicare payment systems. Thus, we proposed to implement the new OMB delineations as described in the February 28, 2013 OMB Bulletin No. 13–01 beginning in CY 2015 to more accurately identify urban and rural areas for ambulance fee schedule payment purposes. We believe that the updated OMB delineations more realistically reflect rural and urban populations, and that the use of such delineations under the ambulance fee schedule would result in more accurate payment. Under the ambulance fee schedule, consistent with our current definitions of urban and rural areas (§ 414.605), MSAs would continue to be recognized as urban areas, while Micropolitan and other areas outside MSAs, and rural census tracts within MSAs (as discussed below), would be recognized as rural areas.

In addition to the OMB's statistical area delineations, the current geographic areas used in the ambulance fee schedule also are based on rural census tracts determined under the most recent version of the Goldsmith Modification. These rural census tracts are considered rural areas under the ambulance fee schedule (see § 414.605). For certain rural add-ons, section 1834(l) of the Act requires that we use the most recent version of the Goldsmith Modification to determine rural census tracts within MSAs. In the CY 2007 PFS final rule (71 FR 69714 through 69716), we adopted the most recent (at that time) version of the Goldsmith Modification, designated as Rural-Urban Commuting Area (RUCA) codes. RUCA codes use urbanization, population density, and daily commuting data to categorize every census tract in the country. For a discussion about RUCA codes, we refer the reader to the CY 2007 PFS final rule (71 FR 69714 through 69716). As stated previously, on February 28, 2013, OMB issued OMB Bulletin No. 13–01, which established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas. Several modifications of the RUCA codes were necessary to take into account updated commuting data and the revised OMB delineations. We refer readers to the U.S. Department of Agriculture's Economic Research Service Web site for a detailed listing of updated RUCA codes found at *http://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx*. The updated RUCA code definitions were introduced in late 2013 and are based on data from the 2010 decennial census and the 2006–10 American Community Survey. We proposed to adopt the most recent modifications of the RUCA codes beginning in CY 2015, to recognize levels of rurality in census tracts located in every county across the nation, for purposes of payment under the ambulance fee schedule. In the CY 2015 PFS proposed rule (79 FR 40373), we stated that if we adopt the most recent RUCA codes, many counties that are designated as urban at the county level based on population would have rural census tracts within them that would be recognized as rural areas through our use of RUCA codes.

As we stated in the CY 2015 PFS proposed rule (79 FR 40373 through 40374), the 2010 Primary RUCA codes are as follows:

(1) Metropolitan area core: primary flow with an urbanized area (UA).

(2) Metropolitan area high commuting: primary flow 30 percent or more to a UA.

(3) Metropolitan area low commuting: primary flow 10 to 30 percent to a UA.

(4) Micropolitan area core: primary flow within an Urban Cluster of 10,000 to 49,999 (large UC).

(5) Micropolitan high commuting: primary flow 30 percent or more to a large UC.

(6) Micropolitan low commuting: primary flow 10 to 30 percent to a large UC.

(7) Small town core: primary flow within an Urban Cluster of 2,500 to 9,999 (small UC).

(8) Small town high commuting: primary flow 30 percent or more to a small UC.

(9) Small town low commuting: primary flow 10 to 30 percent to a small UC.

(10) Rural areas: primary flow to a tract outside a UA or UC.

Based on this classification, and consistent with our current policy (71 FR 69715), we proposed to continue to designate any census tracts falling at or above RUCA level 4.0 as rural areas for purposes of payment for ambulance services under the ambulance fee schedule. As discussed in the CY 2007 PFS final rule (71 FR 69715), the Office of Rural Health Policy within the Health Resources and Services Administration (HRSA) determines eligibility for its rural grant programs through the use of the RUCA code methodology. Under this methodology, HRSA designates any census tract that falls in RUCA level 4.0 or higher as a rural census tract. In addition to designating any census tracts falling at or above RUCA level 4.0 as rural areas, under the updated RUCA code definitions, HRSA has also designated as rural census tracts those census tracts with RUCA codes 2 or 3 that are at least 400 square miles in area with a population density of no more than 35 people. We refer readers to

HRSA's Web site: *ftp://ftp.hrsa.gov/ruralhealth/Eligibility2005.pdf* for additional information. Consistent with the HRSA guidelines discussed above, we proposed, beginning in CY 2015, to designate as rural areas (1) those census tracts that fall at or above RUCA level 4.0, and (2) those census tracts that fall within RUCA levels 2 or 3 that are at least 400 square miles in area with a population density of no more than 35 people. We stated in the CY 2015 PFS proposed rule (79 FR 40374) that we continue to believe that HRSA's guidelines accurately identify rural census tracts throughout the country, and thus would be appropriate to apply for ambulance payment purposes. We invited comments on this proposal.

We stated in the CY 2015 PFS proposed rule (79 FR 40374) that the adoption of the most current OMB delineations and the updated RUCA codes would affect whether certain areas are recognized as rural or urban. The distinction between urban and rural is important for ambulance payment purposes because urban and rural transports are paid differently. The determination of whether a transport is urban or rural is based on the point of pick-up for the transport, and thus a transport is paid differently depending on whether the point of pick-up is in an urban or a rural area. During claims processing, a geographic designation of urban, rural, or super rural is assigned to each claim for an ambulance transport based on the point of pick-up ZIP code that is indicated on the claim.

Currently, section 1834(l)(12) of the Act (as amended by section 104(b) of the PAMA) specifies that, for services furnished during the period July 1, 2004 through March 31, 2015, the payment amount for the ground ambulance base rate is increased by a ''percent increase'' (Super Rural Bonus) where the ambulance transport originates in a ''qualified rural area,'' which is a rural area that we determine to be in the lowest 25th percentile of all rural populations arrayed by population density (also known as a ''super rural area''). We implement this Super Rural Bonus in § 414.610(c)(5)(ii). We stated in the CY 2015 PFS proposed rule (79 FR 40374) that adoption of the revised OMB delineations and the updated RUCA codes would have no negative impact on ambulance transports in super rural areas, as none of the current super rural areas would lose their status due to the revised OMB delineations and the updated RUCA codes.

As we stated in the CY 2015 PFS proposed rule (79 FR 40374), the adoption of the new OMB delineations and the updated RUCA codes would affect whether or not transports would be eligible for other rural adjustments under the ambulance fee schedule statute and regulations. For ground ambulance transports where the point of pick-up is in a rural area, the mileage rate is increased by 50 percent for each of the first 17 miles (§ 414.610(c)(5)(i)). For air ambulance services where the point of pick-up is in a rural area, the total payment (base rate and mileage rate) is increased by 50 percent (§ 414.610(c)(5)(i)). Furthermore, under section 1834(l)(13) of the Act (as amended by section 104(a) of the PAMA), for ground ambulance transports furnished through March 31, 2015, transports originating in rural areas are paid based on a rate (both base rate and mileage rate) that is 3 percent higher than otherwise is applicable. (See also § 414.610(c)(1)(ii)).

We stated in the CY 2015 PFS proposed rule (79 FR 40374) that if we adopt OMB's revised delineations and the updated RUCA codes, ambulance providers and suppliers that pick up Medicare beneficiaries in areas that would be Micropolitan or otherwise outside of MSAs based on OMB's revised delineations or in a rural census tract of an MSA based on the updated RUCA codes (but are currently within urban areas) may experience increases in payment for such transports because they may be eligible for the rural adjustment factors discussed above, while those ambulance providers and suppliers that pick up Medicare beneficiaries in areas that would be urban based on OMB's revised delineations and the updated RUCA codes (but are currently in Micropolitan Areas or otherwise outside of MSAs, or in a rural census tract of an MSA) may experience decreases in payment for such transports because they would no longer be eligible for the rural adjustment factors discussed above.

The use of the revised OMB delineations and the updated RUCA codes would mean the recognition of new urban and rural boundaries based on the population migration that occurred over a 10-year period, between 2000 and 2010. In the CY 2015 PFS proposed rule (79 FR 40374), we stated that, based on the latest United States Postal Service (USPS) ZIP code file, there are a total of 42,914 ZIP codes in the U.S. We stated in the proposed rule that the geographic designations for approximately 99.48 percent of ZIP codes would be unchanged by OMB's revised delineations and the updated RUCA codes, and that a similar number of ZIP codes would change from rural to urban (122, or 0.28 percent) as would change from urban to rural (100, or 0.23 percent). We stated in the proposed rule that, in general, it was expected that ambulance providers and suppliers in 100 ZIP codes within 11 states may experience payment increases if we adopt the revised OMB delineations and the updated RUCA codes, as these areas would be redesignated from urban to rural. We stated that the state of Ohio would have the most ZIP codes changing from urban to rural with a total of 40, or 2.69 percent. We also stated in the CY 2015 PFS proposed rule that ambulance providers and suppliers in 122 ZIP codes within 22 states may experience payment decreases if we adopt the revised OMB delineations and the updated RUCA codes, as these areas would be redesignated from rural to urban. We stated that the state of West Virginia would have the most ZIP codes changing from rural to urban (17, or 1.82 percent), while Connecticut would have the greatest percentage of ZIP codes changing from rural to urban (15 ZIP codes, or 3.37 percent). Our findings were illustrated in Table 17 of the CY 2015 PFS proposed rule (79 FR 40375).

We stated in the CY 2015 PFS proposed rule (79 FR 40375 and 40376) that we believe the most current OMB statistical area delineations, coupled with the updated RUCA codes, more accurately reflect the contemporary urban and rural nature of areas across the country, and that use of the most current OMB delineations and RUCA codes under the ambulance fee schedule would enhance the accuracy of ambulance fee schedule payments. We solicited comments on our proposal to implement the new OMB delineations and the updated RUCA codes as discussed above beginning in CY 2015, for purposes of payment under the Medicare ambulance fee schedule.

We received four comments from two associations representing ambulance service providers and suppliers and two ambulance suppliers on our proposal to implement the new OMB delineations and the updated RUCA codes for purposes of payment under the Medicare ambulance fee schedule. Those comments are summarized below along with our responses.

Comment: All of the commenters agreed with CMS that it is appropriate to adjust the geographic area designations periodically so that the ambulance fee schedule reflects population shifts.

Response: We appreciate the support of the commenters.

Comment: Commenters expressed concern that the analysis of the proposed modification in the CY 2015 PFS proposed rule did not describe the actual impact of the proposed change

because it did not take into account the most recent modifications to the RUCA codes. When these codes are applied, the commenters stated that there would be substantially more ZIP codes that would shift. The commenters estimated that more than 1,500 ZIP codes would shift from rural to urban and about three times the number of ZIP codes identified in the proposed rule would change from urban to rural. The commenters also stated that some ZIP codes would no longer have super rural status.

Response: The commenters are correct that the analysis published in the CY 2015 PFS proposed rule (see Table 17 (79 FR 40375)) presented the impact of the revised OMB delineations only and did not include the impact of the updated RUCA codes. We did not receive the ZIP code approximation of the 2010 RUCA codes file in time to be included in our analysis in the proposed rule.

We have completed an updated analysis of both the revised OMB delineations and the updated RUCA codes. Based on the latest United States Postal Service (USPS) ZIP code file, there are a total of 42,918 ZIP codes in the U.S. Based on our updated analysis, we have concluded that the geographic designations for approximately 92.02 percent of ZIP codes would be unchanged by OMB's revised delineations and the updated RUCA codes. There are more ZIP codes that would change from rural to urban (3,038 or 7.08 percent) than from urban to rural (387 or 0.90 percent). The differences in the data provided in the proposed rule compared to the final rule are due to inclusion of the updated RUCA codes. In general, it is expected that ambulance providers and suppliers in 387 ZIP codes within 41 states, may experience payment increases under the revised OMB delineations and the updated RUCA codes, as these areas have been redesignated from urban to rural. The state of California has the most ZIP codes changing from urban to rural with a total of 43, or 1.58 percent. Ambulance providers and suppliers in 3,038 ZIP codes within 46 states and Puerto Rico may experience payment decreases under the revised OMB delineations and the updated RUCA codes, as these areas have been redesignated from rural to urban. The state of Pennsylvania has the most ZIP codes changing from rural to urban (293, or 13.06 percent), while West Virginia has the greatest percentage of ZIP codes changing from rural to urban (269 ZIP codes, or 28.74 percent). Our findings are illustrated in Table 47.

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TABLE 47: Updated ZIP Codes Analysis Based on OMB's Revised Delineations and Updated RUCA Codes

State/ Territory*	Total ZIP Codes	Total ZIP Codes Changed Rural to Urban	Percentage of Total ZIP Codes	Total ZIP Codes Changed Urban to Rural	Percentage of Total ZIP Codes	Total ZIP Codes Not Changed	Percentage of Total ZIP Codes Not Changed
AK	276	0	0.00%	0	0.00%	276	100.00%
AL	854	83	9.72%	8	0.94%	763	89.34%
AR	725	41	5.66%	6	0.83%	678	93.52%
AS	1	0	0.00%	0	0.00%	1	100.00%
AZ	569	21	3.69%	7	1.23%	541	95.08%
CA	2723	94	3.45%	43	1.58%	2586	94.97%
CO	677	4	0.59%	9	1.33%	664	98.08%
CT	445	56	12.58%	0	0.00%	389	87.42%
DC	303	0	0.00%	0	0.00%	303	100.00%
DE	99	6	6.06%	0	0.00%	93	93.94%
EK	63	0	0.00%	0	0.00%	63	100.00%
EM	856	71	8.29%	2	0.23%	783	91.47%
FL	1513	105	6.94%	9	0.59%	1399	92.47%
FM	4	0	0.00%	0	0.00%	4	100.00%
GA	1032	101	9.79%	4	0.39%	927	89.83%
GU	21	0	0.00%	0	0.00%	21	100.00%
HI	143	9	6.29%	3	2.10%	131	91.61%
IA	1080	42	3.89%	3	0.28%	1035	95.83%
ID	335	3	0.90%	0	0.00%	332	99.10%
IL	1628	159	9.77%	7	0.43%	1462	89.80%
IN	1000	110	11.00%	7	0.70%	883	88.30%
KY	1030	81	7.86%	5	0.49%	944	91.65%
LA	739	101	13.67%	1	0.14%	637	86.20%
MA	751	14	1.86%	6	0.80%	731	97.34%
MD	630	84	13.33%	0	0.00%	546	86.67%
ME	505	19	3.76%	12	2.38%	474	93.86%
MH	2	0	0.00%	0	0.00%	2	100.00%
MI	1185	63	5.32%	13	1.10%	1109	93.59%
MN	1043	47	4.51%	7	0.67%	989	94.82%
MP	3	0	0.00%	0	0.00%	3	100.00%
MS	541	36	6.65%	1	0.18%	504	93.16%
MT	411	0	0.00%	3	0.73%	408	99.27%
NC	1101	163	14.80%	6	0.54%	932	84.65%
ND	419	2	0.48%	0	0.00%	417	99.52%
NE	632	7	1.11%	6	0.95%	619	97.94%
NH	292	6	2.05%	2	0.68%	284	97.26%
NJ	747	1	0.13%	2	0.27%	744	99.60%
NM	438	4	0.91%	2	0.46%	432	98.63%
NV	257	4	1.56%	2	0.78%	251	97.67%

State/ Territory*	Total ZIP Codes	Total ZIP Codes Changed Rural to Urban	Percentage of Total ZIP Codes	Total ZIP Codes Changed Urban to Rural	Percentage of Total ZIP Codes	Total ZIP Codes Not Changed	Percentage of Total ZIP Codes Not Changed
NY	2246	180	8.01%	42	1.87%	2024	90.12%
OH	1487	80	5.38%	34	2.29%	1373	92.33%
OK	791	23	2.91%	7	0.88%	761	96.21%
OR	495	26	5.25%	9	1.82%	460	92.93%
PA	2244	293	13.06%	38	1.69%	1913	85.25%
PR	177	21	11.86%	0	0.00%	156	88.14%
PW	2	0	0.00%	0	0.00%	2	100.00%
RI	91	2	2.20%	1	1.10%	88	96.70%
SC	543	91	16.76%	2	0.37%	450	82.87%
SD	418	0	0.00%	1	0.24%	417	99.76%
TN	814	82	10.07%	12	1.47%	720	88.45%
TX	2726	155	5.69%	32	1.17%	2539	93.14%
UT	359	2	0.56%	0	0.00%	357	99.44%
VA	1277	147	11.51%	13	1.02%	1117	87.47%
VI	16	0	0.00%	0	0.00%	16	100.00%
VT	309	15	4.85%	0	0.00%	294	95.15%
WA	744	29	3.90%	6	0.81%	709	95.30%
WI	919	66	7.18%	5	0.54%	848	92.27%
WK	711	16	2.25%	5	0.70%	690	97.05%
WM	342	4	1.17%	3	0.88%	335	97.95%
WV	936	269	28.74%	0	0.00%	667	71.26%
WY	198	0	0.00%	1	0.51%	197	99.49%
TOTALS	**42918**	**3038**	**7.08%**	**387**	**0.90%**	**39493**	**92.02%**

* ZIP code analysis includes U.S. States and Territories (FM- Federated States of Micronesia, GU – Guam, MH- Marshall Islands, MP-Northern Mariana Islands, PW- Palau, AS- American Samoa; VI- Virgin Islands; PR- Puerto Rico). [Missouri is divided into east and west regions due to work distribution of the Medicare Administrative Contractors (MACs) : EM- East Missouri, WM – West Missouri. Johnson and Wyandotte counties in Kansas were changed as of January 2010 to East Kansas (EK) and the rest of the state is West Kansas (WK).

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As discussed above, in the CY 2015 PFS proposed rule (79 FR 40374), we proposed to designate as rural those census tracts that fall in RUCA codes 2 or 3 that are at least 400 square miles in area with a population density of no more than 35 people. However, upon further analysis, we have determined that it is not feasible to implement this proposal. Payment under the ambulance fee schedule is based on the ZIP codes; therefore, if the ZIP code is predominantly metropolitan but has some rural census tracts, we do not split the ZIP code areas to distinguish further granularity to provide different payments within the same ZIP code. We believe that payment for all ambulance transportation services at the ZIP code level provides a consistent payment system. Therefore, such census tracts were not considered rural areas in the updated analysis set forth above.

For more detail on the impact of these changes, in addition to Table 47, the following files are available through the Internet on the AFS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/index.html*: ZIP codes by state that changed from urban to rural, ZIP codes by state that changed from rural to urban, list of ZIP codes with RUCA code designations, and a complete list of ZIP codes identifying their designation as super rural, rural or urban.

As reflected in Table 47, our findings are generally consistent with the commenters' findings that more than 1,500 ZIP codes would change from rural to urban (our updated analysis indicates that 3,038 ZIP codes are changing), and that about three times the number of ZIP codes identified in the proposed rule (100) would change from urban to rural (our updated analysis indicates 387 ZIP codes are changing).

As we stated in the proposed rule (79 FR 40374), none of the current super rural areas will lose their super rural status upon implementation of the revised OMB delineations and the updated RUCA codes.

Comment: One commenter suggested that we delay the implementation of the adjustment until CY 2016 to allow CMS sufficient time to publish the changes in

rural and urban status and allow all interested parties to provide comments on the proposal. In addition to delaying implementation, the commenter suggested implementing a 4-year transition that would phase-in the payment reduction over a specified period for those ZIP codes losing rural status.

Other commenters requested that the implementation of the geographic adjustments outlined in the proposed rule be delayed until such time as the data is available to complete a full and accurate analysis of the ZIP codes affected and the financial impact to industry. Absent such a delay, the commenters stated that the final rule must clarify, in a complete and transparent manner, the accuracy of the analysis used in the proposed rule.

Response: We believe that ambulance providers and suppliers had sufficient notice of and opportunity to comment on the proposed adoption of the revised OMB delineations and the updated RUCA codes under the ambulance fee schedule, and thus we do not believe a delay in implementation is warranted. In the proposed rule, we proposed to adopt the revised OMB delineations as set forth in OMB Bulletin No. 13–01 and the updated RUCA codes for purposes of payment under the ambulance fee schedule consistent with the policy we implemented in CY 2007 (see the CY 2007 PFS final rule (71 FR 69713 through 69716)). We explained in the proposed rule that the adoption of the revised OMB delineations and updated RUCA codes would affect the urban/rural designation of certain areas, and thus would affect whether transports in certain areas would be eligible for rural adjustments under the ambulance fee schedule. In addition, OMB Bulletin No. 13–01was available on February 28, 2013, and contained additional information regarding the changes in OMB geographic area delineations. As discussed above, the ZIP code analysis set forth in the proposed rule reflected the impact of the revised OMB delineations. The 2010 RUCA codes and definitions were available on December 31, 2013 on the U.S. Department of Agriculture's Economic Research Service's Web site, which provided ambulance providers and suppliers with additional information regarding changes to the level of rurality in census tracts. Furthermore, section 1834(l) requires that we use the most recent modification of the Goldsmith Modification to determine rural census tracts for purposes of certain rural add-ons, and our established policy, as set forth in § 414.605, is that rural areas include rural census tracts as determined under the most recent version of the Goldsmith modification.

As discussed above and in the CY 2015 PFS proposed rule, we believe the most current OMB statistical area delineations, coupled with the updated RUCA codes, more accurately reflect the contemporary urban and rural nature of areas across the country, and thus we believe the use of the most current OMB delineations and RUCA codes under the ambulance fee schedule will enhance the accuracy of ambulance fee schedule payments. We believe that it is important to use the most current OMB delineations and RUCA codes available as soon as reasonably possible to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts. Because we believe the revised OMB delineations and updated RUCA codes more accurately identify urban and rural areas and enhance the accuracy of the Medicare ambulance fee schedule, we do not believe a delay in implementation or a transition period would be appropriate. Areas that lose their rural status and become urban have become urban because of recent population shifts. We believe it is important to base payment on the most accurate and up-to-date geographic area delineations available. Furthermore, we believe a delay would disadvantage the ambulance providers or suppliers experiencing payment increases based on these updated and more accurate OMB delineations and RUCA codes.

Finally, given the relatively small percentage of ZIP codes affected by the revised OMB delineations and updated RUCA codes (a total of 3,425 ZIP codes changing their urban/rural status out of 42,918 ZIP codes, or 7.98 percent), we do not believe that a delay is warranted. As commenters requested, we have included in Table 47 our updated analysis of the impact of adopting the revised OMB delineations and the updated RUCA codes.

Comment: One commenter recommended that if any ZIP codes would lose their super rural status as a result of the proposed adoption of the revised OMB delineations and the updated RUCA codes, then CMS should grandfather the current super rural ZIP codes. Another commenter stated that the ambulance providers must have verification from CMS that the super rural ZIP codes will not be affected by the changes described in the proposed rule in advance of their implementation in the final rule.

Response: As we stated previously, the adoption of the OMB's revised delineations and the updated RUCA codes will have no negative impact on ambulance transports in super rural areas, as none of the current super rural areas will lose their status upon implementation of the revised OMB delineations and the updated RUCA codes. Current areas designated as super rural areas will continue to be eligible for the super rural bonus.

After consideration of the public comments received, and for the reasons discussed above, we are finalizing our proposals to adopt, beginning in CY 2015, the revised OMB delineations as set forth in OMB's February 28, 2013 bulletin (No. 13–01) and the most recent modifications of the RUCA codes for purposes of payment under the ambulance fee schedule. As we proposed, using the updated RUCA codes definitions, we will continue to designate any census tracts falling at or above RUCA level 4.0 as rural areas. However, as discussed above, we are not finalizing our proposal to designate as rural those census tracts that fall within RUCA codes 2 or 3 that are at least 400 square miles in area with a population density of no more than 35 people. Finally, as discussed above, none of the current super rural areas will lose their super rural status upon implementation of the revised OMB delineations and the updated RUCA codes.

C. Clinical Laboratory Fee Schedule

In the CY 2014 PFS final rule with comment period (78 FR 74440 through 74445, 74820), we finalized a process under which we would reexamine the payment amounts for test codes on the Clinical Laboratory Fee Schedule (CLFS) for possible payment revision based on technological changes beginning with the CY 2015 proposed rule, and we codified this process at § 414.511. After we finalized this process, the Congress enacted the PAMA. Section 216 of the PAMA creates new section 1834A of the Act, which requires us to implement a new Medicare payment system for clinical diagnostic laboratory tests based on private payor rates. Section 216 of the PAMA also rescinds the statutory authority in section 1833(h)(2)(A)(i) of the Act for adjustments based on technological changes for tests furnished on or after April 1, 2014 (PAMA's enactment date). As a result of these provisions, we did not propose any revisions to payment amounts for test codes on the CLFS based on technological changes, and we proposed to remove § 414.511.

We did not receive any public comments on this proposal. Therefore, we are finalizing our proposal to remove § 414.511. In addition, we will establish through rulemaking the parameters for

rural areas, based on recent utilization of similar services already on the telehealth list, we estimate no significant impact on PFS expenditures from these additions.

E. Geographic Practice Cost Indices (GPCIs)

As discussed in section II.D of this final rule with comment period, we are required to review and revise the GPCIs at least every 3 years and phase in the adjustment over 2 years (if there has not been an adjustment in the past year). For CY 2015, we are not making any revisions related to the data or the methodologies used to calculate the GPCIs except in regard to the Virgin Islands locality discussed in section II.D. However, since the 1.0 work GPCI floor provided in section 1848(e)(1)(E) of the Act is set to expire on March 31, 2015, we have included two set of GPCIs and GAFs for CY 2015—one set for January 1, 2015 through March 31, 2015 and another set for April 1, 2015 through December 31, 2015. The April 1, 2015 through December 31, 2015 GPCIs and GAFs reflect the statutory expiration of the 1.0 work GPCI floor.

F. Other Provisions of the Final Rule With Comment Period Regulation

1. Ambulance Fee Schedule

The statutory ambulance extender provisions are self-implementing. As a result, there are no policy proposals associated with these provisions or associated impact in this rule. We are finalizing our proposal to correct the dates in the Code of Federal Regulations (CFR) at § 414.610(c)(1)(ii) and § 414.610(c)(5)(ii) to conform the regulations to these self-implementing statutory provisions.

The geographic designations for approximately 92.02 percent of ZIP codes would be unchanged if we adopt OMB's revised statistical area delineations and the updated RUCA codes. There are more ZIP codes that would change from rural to urban (3,038 or 7.08 percent) than from urban to rural (387 or 0.90 percent). The differences in the data provided in the proposed rule compared to the final rule are due to inclusion of the updated RUCA codes. In general, it is expected that ambulance providers and suppliers in 387 ZIP codes within 41 states may experience payment increases under the revised OMB delineations and the updated RUCA codes, as these areas have been redesignated from urban to rural. Ambulance providers and suppliers in 3, 038 ZIP codes within 46 states and Puerto Rico may experience payment decreases under the revised OMB delineations and the updated RUCA codes, as these areas have been redesignated from rural to urban. None of the current super rural areas will lose their status upon implementation of the revised OMB delineations and the updated RUCA codes. We estimate that the adoption of the revised OMB delineations and the updated RUCA codes would have a small fiscal impact on the Medicare program.

2. Clinical Laboratory Fee Schedule

There is no impact because we are merely deleting language from the Code of Federal Regulations.

3. Removal of Employment Requirements for Services Furnished ''Incident to'' RHC and FQHC Visits

The removal of employment requirements for services furnished ''incident to'' RHC and FQHC visits will provide RHCs and FQHCs with greater flexibility in meeting their staffing needs, which may result in increasing access to care in underserved areas. There is no cost to the federal government, and we cannot estimate a cost savings for RHCs or FQHCs.

4. Access to Identifiable Data for the Center for Medicare and Medicaid Models

Given that, in general, participants in Innovation Center models receive funding support to participate in model tests, we do not anticipate an impact. In those cases where there is a cost associated with the data reporting, such costs will vary by project, and thus cannot be laid out with specificity here. We do, however, expect the costs to be covered by payments associated with the model test.

5. Local Coverage Determination Process for Clinical Diagnostic Laboratory Tests

The Local Coverage Determination Process for Clinical Diagnostic Laboratory Tests will not be finalized. Therefore, there is no impact to CY 2015 physician payments under the PFS.

6. Private Contracting/Opt Out

We corrected cross-references and outdated terminology in the regulations that we inadvertently neglected to revise, and changed the appeals process used for certain appeals relating to opt-out private contracting. We anticipate no or minimal impact as a result of these corrections.

7. Payment Policy for Locum Tenens Physicians

We did not issue any new or revised requirements. There is no impact.

8. Reports of Payments or Other Transfers of Value to Covered Recipients

The changes to the Transparency Reports and Reporting of Physician Ownership or Investment Interests in section III.I of this final rule with comment period would not impact CY 2015 physician payments under the PFS.

9. Physician Compare

There will be no impact for the Physician Compare Web site because we are not collecting any new information specifically for the Physician Compare Web site. The information derived for Physician Compare comes from other programs that already collect data, including but not limited to the Physician Quality Reporting System (PQRS) and the Medicare Shared Savings Program.

10. Physician Quality Reporting System

According to the 2012 Reporting Experience, ''more than 1.2 million eligible professionals were eligible to participate in the 2012 PQRS, Medicare Shared Savings Program, and Pioneer ACO Model.'' [40] In this burden estimate, we assume that 1.2 million eligible professionals, the same number of eligible professionals eligible to participate in the PQRS in 2012, will be eligible to participate in the PQRS. Since all eligible professionals are subject to the 2017 PQRS payment adjustment, we estimate that all 1.2 million eligible professionals will participate, (which includes, for the purposes of this discussion, being eligible for the 2017 PQRS payment adjustment) in the PQRS in 2015 for purposes of meeting the criteria for satisfactory reporting (or, in lieu of satisfactory reporting, satisfactory participation in a QCDR) for the 2017 PQRS payment adjustment.

Historically, the PQRS has never experienced 100 percent participation in reporting for the PQRS. Therefore, we believe that although 1.2 million eligible professionals will be subject to the 2017 PQRS payment adjustment, not all eligible participants will actually report quality measures data for purposes of the 2017 PQRS payment adjustment. In this burden estimate, we will only provide burden estimates for the eligible professionals and group practices who attempt to submit quality measures data for purposes of the 2017 PQRS payment

[40] Centers for Medicare and Medicaid Services, *2012 Reporting Experience Including Trends (2007–2013): Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program,* March 14, 2014, at xiii.

professionals, for the 12-month 2017 PQRS payment adjustment reporting period, report all CAHPS for PQRS survey measures via a CMS-certified survey vendor and report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 of the NQS domains using the direct EHR product that is CEHRT or EHR data submission vendor product that is CEHRT. If less than 6 measures apply to the group practice, the group practice must report up to 5 measures. Of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, the group practice must report on at least 1 measure for which there is Medicare patient data.

(vii) *Via a Certified Survey Vendor in addition to the GPRO Web interface.* (A) For a group practice of 25 or more eligible professionals, for the 12-month 2017 PQRS payment adjustment reporting period, report all CAHPS for PQRS survey measures via a CMS-certified survey vendor and report on all measures included in the GPRO web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice would report on 100 percent of assigned beneficiaries. A group practice must report on at least 1 measure for which there is Medicare patient data.

(B) [Reserved]

(k) * * *

(4) *Satisfactory participation criteria for individual eligible professionals for the 2017 PQRS payment adjustment.* An individual eligible professional who wishes to meet the criteria for satisfactory participation in a QCDR for the 2017 PQRS payment adjustment must report information on quality measures identified by the QCDR in one of the following manner:

(i) For the 12-month 2017 PQRS payment adjustment reporting period, report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, and report each measure for at least 50 percent of the eligible professional's patients. Of these measures, report on at least 2 outcome measures, or, if 2 outcomes measures are not available, report on at least 2 outcome measures and at least 1 of the following types of measures—resource use, patient experience of care, efficiency/appropriate use or patient safety.

(ii) [Reserved]

* * * * *

(m) * * *

(1) To request an informal review for reporting periods that occur prior to 2014, an eligible professional or group practice must submit a request to CMS within 90 days of the release of the feedback reports. To request an informal review for reporting periods that occur in 2014 and subsequent years, an eligible professional or group practice must submit a request to CMS within 60 days of the release of the feedback reports. The request must be submitted in writing and summarize the concern(s) and reasons for requesting an informal review and may also include information to assist in the review.

* * * * *

(3) If, during the informal review process, CMS finds errors in data that was submitted by a third-party vendor on behalf of an eligible professional or group practice using either the qualified registry, EHR data submission vendor, or QCDR reporting mechanisms, CMS may allow for the resubmission of data to correct these errors.

(i) CMS will not allow resubmission of data submitted via claims, direct EHR, and the GPRO web interface reporting mechanisms.

(ii) CMS will only allow resubmission of data that was already previously submitted to CMS.

(iii) CMS will only accept data that was previously submitted for the reporting periods for which the corresponding informal review period applies.

* * * * *

§ 414.511 [Removed]

■ 33. Section § 414.511 is removed.

■ 34. Section 414.610 is amended by revising paragraphs (c)(1)(ii) introductory text and (c)(5)(ii) to read as follows:

§ 414.610 Basis of payment.

* * * * *

(c) * * *

(1) * * *

(ii) For services furnished during the period July 1, 2008 through March 31, 2015, ambulance services originating in:

* * * * *

(5) * * *

(ii) For services furnished during the period July 1, 2004 through March 31, 2015, the payment amount for the ground ambulance base rate is increased by 22.6 percent where the point of pickup is in a rural area determined to be in the lowest 25 percent of rural population arrayed by population density. The amount of this increase is based on CMS's estimate of the ratio of the average cost per trip for the rural areas in the lowest quartile of population compared to the average cost per trip for the rural areas in the highest quartile of population. In making this estimate, CMS may use data provided by the GAO.

* * * * *

■ 35. Section 414.1200 is amended by revising paragraphs (a) and (b)(5) to read as follows:

§ 414.1200 Basis and scope.

(a) *Basis.* This subpart implements section 1848(p) of the Act by establishing a payment modifier that provides for differential payment starting in 2015 to a group of physicians and starting in 2017 to a group and a solo practitioner under the Medicare Physician Fee Schedule based on the quality of care furnished compared to cost during a performance period.

(b) * * *

(5) Additional measures for groups and solo practitioners.

* * * * *

■ 36. Section 414.1205 is amended by—

■ A. Revising the definitions of ''Group of physicians'' and ''Value-based payment modifier.''

■ B. Adding the definition of ''Solo practitioner'' in alphabetical order.

The addition and revisions read as follows:

§ 414.1205 Definitions.

* * * * *

Group of physicians (Group) means a single Taxpayer Identification Number (TIN) with 2 or more eligible professionals, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN.

* * * * *

Solo practitioner means a single Taxpayer Identification Number (TIN) with one eligible professional who is identified by an individual National Provider Identifier (NPI) billing under the TIN.

* * * * *

Value-based payment modifier means the percentage as determined under § 414.1270 by which amounts paid to a group or solo practitioner under the Medicare Physician Fee Schedule established under section 1848 of the Act are adjusted based upon a comparison of the quality of care furnished to cost as determined by this subpart.

■ 37. Section 414.1210 is amended by—

■ A. Adding paragraphs (a)(3), (a)(4), (b)(2), (b)(3), and (b)(4).

■ B. Revising paragraph (c).

The additions and revision reads as follows: