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.