§ 414.1215 Performance and payment adjustment periods for the value-based payment modifier.

(a) The performance period is calendar year 2013 for value-based payment modifier adjustments made in the calendar year 2015 payment adjustment period.

(b) The performance period is calendar year 2014 for value-based payment modifier adjustments made in the calendar year 2016 payment adjustment period.

(c) The performance period is calendar year 2015 for value-based payment modifier adjustments made in the calendar year 2017 payment adjustment period.

§ 414.1220 Reporting mechanisms for the value-based payment modifier.

Groups of physicians subject to the value-based payment modifier (or individual eligible professionals within such groups) may submit data on quality measures as specified under the Physician Quality Reporting System using the reporting mechanisms for which they are eligible.

§ 414.1225 Alignment of Physician Quality Reporting System quality measures and quality measures for the value-based payment modifier.

All of the quality measures for which groups of physicians or individual eligible professionals are eligible to report under the Physician Quality Reporting System in a given calendar year are used to calculate the value-based payment modifier for the applicable payment adjustment period, as defined in §414.1215, to the extent a group of physicians or individual eligible professionals within such group submits data on such measures.

§ 414.1230 Additional measures for groups of physicians.

The value-based payment modifier includes the following additional quality measures for all groups of physicians subject to the value-based payment modifier:

(a) A composite of rates of potentially preventable hospital admissions for heart failure, chronic obstructive pulmonary disease, and diabetes. The rate of potentially preventable hospital admissions for diabetes is a composite measure of uncontrolled diabetes, short term diabetes complications and lower extremity amputation for diabetes.

(b) A composite of rates of potentially preventable hospital admissions for dehydration, urinary tract infections, and bacterial pneumonia.

(c) Rates of an all-cause hospital re-admissions measure.

§ 414.1235 Cost measures.

(a) Included measures. Beginning with the CY 2016 payment adjustment period, costs for groups of physicians subject to the value-based payment modifier are assessed based on a cost composite comprised of the following 6 cost measures (only the measures identified in paragraphs (a)(1) through (5) of this section are included for the value-based payment modifier for the CY 2015 payment adjustment period):

(1) Total per capita costs for all attributed beneficiaries.

(2) Total per capita costs for all attributed beneficiaries with diabetes.

(3) Total per capita costs for all attributed beneficiaries with chronic obstructive pulmonary disease.

(4) Total per capita costs for all attributed beneficiaries with coronary artery disease.

(5) Total per capita costs for all attributed beneficiaries with heart failure.

(6) Medicare Spending per Beneficiary associated with an acute inpatient hospitalization.

(b) Included payments. Cost measures enumerated in paragraph (a) of this section include all fee-for-service payments made under Medicare Part A and Part B.

(c) Cost measure adjustments. (1) Payments under Medicare Part A and Part
B will be adjusted using CMS’ payment standardization methodology to ensure fair comparisons across geographic areas.

(2) The CMS-HCC model (and adjustments for ESRD status) is used to adjust standardized payments for the measures listed at paragraphs (a)(1) through (5) of this section.

(3) The beneficiary’s age and severity of illness are used to adjust the Medicare Spending per Beneficiary measure as specified in paragraph (a)(6) of this section.

[78 FR 74821, Dec. 10, 2013]

§ 414.1240 Attribution for quality of care and cost measures.

(a) Beneficiaries are attributed to groups of physicians subject to the value-based payment modifier using a method generally consistent with the method of assignment of beneficiaries under § 425.402 of this chapter, for measures other than the Medicare Spending per Beneficiary measure.

(b) For the Medicare Spending per Beneficiary (MSPB) measure, an MSPB episode is attributed to the group of physicians subject to the value-based payment modifier whose eligible professionals submitted the plurality of claims (as measured by allowable charges) under the group’s TIN for Medicare Part B services, rendered during an inpatient hospitalization that is an index admission for the MSPB measure during the applicable performance period described at § 414.1215.

[78 FR 74821, Dec. 10, 2013]

§ 414.1245 Scoring methods for the value-based payment modifier using the quality-tiering approach.

For each quality of care and cost measure, a standardized score is calculated for each group of physicians subject to the value-based payment modifier by dividing—

(a) The difference between their performance rate and the benchmark, by

(b) The measure’s standard deviation.

§ 414.1250 Benchmarks for quality of care measures.

(a) The benchmark for quality of care measures reported through the PQRS using the claims, registries, EHR, 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. In calculating the national benchmark, individuals’ and groups of physicians’ performance rates are weighted by the number of beneficiaries used to calculate the individuals’ or group of physician’s performance rate.

(b) The benchmark for each quality of care measure reported through the PQRS using the administrative claims option is the national mean for that measure’s performance rate during the year prior to the performance period.

§ 414.1255 Benchmarks for cost measures.

(a) For the CY 2015 payment adjustment period, the benchmark for each cost measure is the national mean of the performance rates calculated among all groups of physicians for which beneficiaries are attributed to the group of physicians that are subject to the value-based payment modifier. In calculating the national benchmark, groups of physicians’ performance rates are weighted by the number of beneficiaries used to calculate the group of physician’s performance rate.

(b) Beginning with the CY 2016 payment adjustment period, the cost measures of a group of physicians subject to the value-based payment modifier are adjusted to account for the group’s specialty mix, by computing the weighted average of the national specialty-specific expected costs. Each national specialty-specific expected cost is weighted by the proportion of each specialty in the group, the number of eligible professionals of each specialty in the group, and the number of beneficiaries attributed to the group.

(c) The national specialty-specific expected costs referenced in paragraph (b) of this section are derived by calculating, for each specialty, the average cost of beneficiaries attributed to groups of physicians that include that specialty.

[78 FR 74821, Dec. 10, 2013]

§ 414.1260 Composite scores.

(a)(1) The standardized score for each quality of care measure is classified