

(1) The actual charge for the service provided that payment for such item is not included in the payment amount for other CORF services paid under paragraphs (a) or (c); or

(2) The amount determined using the same methodology for drugs (as defined in §414.704 of this chapter) described in section 1842(o)(1) of the Act provided that payment for such *drug* is not included in the payment amount for other CORF services paid under paragraphs (a) or (c).

(e) *Payment for CORF services when no fee schedule amount for the service.* If there is no fee schedule amount established for a CORF service, payment for the item or service will be the lesser of 80 percent of:

(i) The actual charge for the service provided that payment for such item or service is not included in the payment amount for other CORF services paid under paragraphs (a), (c), or (d) of this section.

(ii) The amount determined under the fee schedule established for a comparable service as specified by the Secretary provided that payment for such item or service is not included in the payment amount for other CORF services paid under paragraphs (a), (c), or (d) of this section.

Subpart N—Value-Based Payment Modifier Under the Physician Fee Schedule

SOURCE: 77 FR 69368, Nov. 16, 2012, unless otherwise noted.

§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) *Scope.* This subpart sets forth the following:

(1) The application of the value-based payment modifier.

(2) Performance and payment adjustment periods.

(3) Reporting mechanisms for the value-based payment modifier.

(4) Alignment of PQRS quality of care measures with the quality measures for the value-based payment modifier.

(5) Additional measures for groups and solo practitioners.

(6) Cost measures.

(7) Attribution for quality of care and cost measures.

(8) Scoring methods for the value-based payment modifier.

(9) Benchmarks for quality of care measures.

(10) Benchmarks for cost measures.

(11) Composite scores.

(12) Reliability of measures.

(13) Payment adjustments.

(14) Value-based payment modifier quality-tiering scoring methodology.

(15) Limitation of review.

(16) Inquiry process.

[77 FR 69368, Nov. 16, 2012, as amended at 79 FR 68005, Nov. 13, 2014]

§414.1205 Definitions.

As used in this subpart, unless otherwise indicated—

Accountable care organization (ACO) has the same meaning given this term under §425.20 of this chapter.

Certified registered nurse anesthetist (CRNA) has the same meaning given this term under section 1861(bb)(2) of the Act.

Critical access hospital has the same meaning given this term under §400.202 of this chapter.

Electronic health record (EHR) has the same meaning given this term under §414.92 of this chapter.

Eligible professional has the same meaning given this term under section 1848(k)(3)(B) of the Act.

Federally Qualified Health Center has the same meaning given this term under §405.2401(b) of this chapter.

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.

Performance period means the calendar year that will be used to assess the quality of care furnished compared to cost.

§ 414.1210

42 CFR Ch. IV (10–1–23 Edition)

Performance rate means the calculated rate for each quality or cost measure such as the percent of times that a particular clinical quality action was reported as being performed, or a particular outcome was attained, for the applicable persons to whom a measure applies as described in the denominator for the measure.

Physician has the same meaning given this term under section 1861(r) of the Act.

Physician assistant (PA), nurse practitioner (NP), and clinical nurse specialist (CNS) have the same meanings given these terms under section 1861(aa)(5) of the Act.

Physician Fee Schedule has the same meaning given this term under part 410 of this chapter.

Physician Quality Reporting System means the system established under section 1848(k) of the Act.

Risk score means the beneficiary risk score derived from the CMS Hierarchical Condition Categories (HCC) model.

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.

Taxpayer Identification Number (TIN) has the same meaning given this term under § 425.20 of this chapter.

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.

[77 FR 69368, Nov. 16, 2012, as amended at 79 FR 68005, Nov. 13, 2014; 80 FR 71382, Nov. 16, 2015]

§ 414.1210 Application of the value-based payment modifier.

(a) The value-based payment modifier is applicable:

(1) For the CY 2015 payment adjustment period, to physicians in groups with 100 or more eligible professionals based on the performance period described at § 414.1215(a).

(2) For the CY 2016 payment adjustment period, to physicians in groups with 10 or more eligible professionals based on the performance period described at § 414.1215(b).

(3) For the CY 2017 payment adjustment period and each subsequent calendar year payment adjustment period, to physicians in groups with 2 or more eligible professionals and to physicians who are solo practitioners based on the performance period for the payment adjustment period as described at § 414.1215.

(4) For the CY 2018 payment adjustment period, to nonphysician eligible professionals who are physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists in groups with 2 or more eligible professionals and to physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists who are solo practitioners based on the performance period for the payment adjustment period as described at § 414.1215.

(b) *Exceptions.* (1) Groups of physicians that are participating in the Medicare Shared Savings Program, the testing of the Pioneer ACO model, or other similar Innovation Center or CMS initiatives shall not be subject to any adjustments under the value-based payment modifier for CY 2015 and CY 2016.

(2) *Application of the value-based payment modifier to participants in the Shared Savings Program.*

(i) For the CY 2017 payment adjustment period and each subsequent calendar year payment adjustment period, the value-based payment modifier is applicable to physicians in groups with 2 or more eligible professionals and to physicians who are solo practitioners that participate in an ACO under the Shared Savings Program during the performance period for the payment adjustment period as described at § 414.1215. The value-based payment modifier for a group or solo practitioner that participates in an ACO under the Shared Savings Program during the performance period is determined based on paragraphs (b)(2)(i)(A) through (D) of this section.