

based payment modifier is based on a query of PECOS that occurs within 10 days of the close of the Physician Quality Reporting System group registration process during the applicable performance period described at §414.1215. Groups are removed from the PECOS-generated list if, based on a claims analysis, the group did not have the required number of eligible professionals, as defined in paragraph (a) of this section, that submitted claims during the performance period for the applicable calendar year payment adjustment period. Solo practitioners are removed from the PECOS-generated list if, based on a claims analysis, the solo practitioner did not submit claims during the performance period for the applicable calendar year payment adjustment period.

(2) Beginning with the CY 2016 payment adjustment period, the size of a group during the applicable performance period will be determined by the lower number of eligible professionals as indicated by the PECOS-generated list or claims analysis.

(3) For the CY 2018 payment adjustment period, the composition of a group during the applicable performance period will be determined based on whether the group includes physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and/or other types of nonphysician eligible professionals as indicated by the PECOS-generated list or claims analysis.

[77 FR 69368, Nov. 16, 2012, as amended at 78 FR 74820, Dec. 10, 2013; 79 FR 68005, Nov. 13, 2014; 80 FR 71382, Nov. 16, 2015; 81 FR 80555, Nov. 15, 2016]

**§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.

(d) The performance period is calendar year 2016 for value-based payment modifier adjustments made in the calendar year 2018 payment adjustment period.

[77 FR 69368, Nov. 16, 2012, as amended at 78 FR 74820, Dec. 10, 2013; 80 FR 71383, Nov. 16, 2015]

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

Solo practitioners and groups 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.

[78 FR 74820, Dec. 10, 2013, as amended at 79 FR 68006, Nov. 13, 2014]

**§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 solo practitioners and groups (or individual eligible professionals within such groups) 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 solo practitioner or a group (or individual eligible professionals within such group) submit data on such measures.

[79 FR 68006, Dec. 13, 2014]

**§414.1230 Additional measures for groups and solo practitioners.**

The value-based payment modifier includes the following additional quality measures (outcome measures) as applicable for all groups and solo practitioners 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, long 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 readmissions measure, except for groups with between two to nine eligible professionals and solo practitioners starting with the CY 2017 payment adjustment period.

[77 FR 69368, Nov. 16, 2012, as amended at 79 FR 68007, Nov. 13, 2014; 80 FR 71383, Nov. 16, 2015]

**§ 414.1235 Cost measures.**

(a) *Included measures.* Beginning with the CY 2016 payment adjustment period, costs for groups and solo practitioners 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 coronary artery disease.

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

(4) Beginning with the CY 2016 payment adjustment period, the cost measures of a group and solo practitioner subject to the value-based payment modifier are adjusted to account for the group's and solo practitioner's specialty mix, by computing the weighted average of the national specialty specific expected costs and comparing this to the group's actual risk adjusted costs. Each national specialty-specific expected cost is weighted by the proportion of Part B payments incurred by each specialty within the group.

(5) The national specialty-specific expected costs referenced in paragraph (c)(4) of this section are derived by calculating, for each specialty, the weighted average of the risk-adjusted costs computed across all groups, where the weight for each group is equal to the number of beneficiaries attributed to the group, times the number of eligible professionals in the group with the relevant specialty, times the proportion of eligible professionals in the group with the relevant specialty.

[78 FR 74821, Dec. 10, 2013, as amended at 79 FR 68007, Nov. 13, 2014; 80 FR 71383, Nov. 16, 2015]

**§ 414.1240 Attribution for quality of care and cost measures.**

(a) Beneficiaries are attributed to groups and solo practitioners 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 or the solo practitioner subject to the