

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

value-based payment modifier whose eligible professionals submitted the plurality of claims (as measured by allowable charges) under the group's or solo practitioner'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.

[79 FR 68007, Nov. 13, 2014]

§ 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 and solo practitioner 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.

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

§ 414.1250 Benchmarks for quality of care measures.

(a) The benchmark for quality of care measures reported through the PQRS using the claims, registries, QCDR, 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, solo practitioners' and groups' (or individual eligible professionals' within such groups) performance rates are weighted by the number of beneficiaries used to calculate the solo practitioners' or groups' (or individual eligible professionals' within such groups) performance rate. Beginning with the CY 2016 performance period, eCQMs reported via EHRs are excluded from the overall benchmark for quality of care measures and separate eCQM benchmarks will be developed. The eCQM benchmark is the national mean for the measure's performance rate during the year prior to the performance period. In calculating the national benchmark, solo practitioners' and groups' (or individual eligible professionals' within such groups) performance rates are weighted by the number of beneficiaries used to calculate the solo practitioners' or

groups' (or individual eligible professionals' within such groups) performance rate.

(b) The benchmark for each outcome measure under § 414.1230, is the national mean for that measure's performance rate during the year prior to the performance period. In calculating the national benchmark, solo practitioners' and groups' (or individual eligible professionals' within such groups) performance rates are weighted by the number of beneficiaries used to calculate the solo practitioners' or groups' (or individual eligible professionals' within such groups) performance rate.

[79 FR 68007, Nov. 13, 2014, as amended at 80 FR 71384, Nov. 16, 2015]

§ 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 benchmark for each cost measure is the national mean of the performance rates calculated among all groups and solo practitioners that meet the minimum number of cases for that measure under § 414.1265(a). In calculating the national benchmark, groups and solo practitioners' performance rates are weighted by the number of beneficiaries used to calculate the group or solo practitioner's performance rate.

[78 FR 74821, Dec. 10, 2013, as amended at 79 FR 68007, Nov. 13, 2014; 80 FR 71384, Nov. 16, 2015]

§ 414.1260 Composite scores.

(a)(1) The standardized score for each quality of care measure is classified into one of the following equally weighted domains to determine the quality composite:

- (i) Patient safety.