

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.

§ 414.1265

- (ii) Patient experience.
- (iii) Care coordination.
- (iv) Clinical care.
- (v) Population/community health.
- (vi) Efficiency.

(2) If a domain includes no measure or does not reach the minimum case size in § 414.1265, the remaining domains are equally weighted to form the quality of care composite.

(b)(1) The standardized score for each cost measure is grouped into two separate and equally weighted domains to determine the cost composite:

(i) Total per capita costs for all attributed beneficiaries: Total per capita costs measure and Medicare Spending per Beneficiary measure; and

(ii) Total per capita costs for all attributed beneficiaries with specific conditions: Diabetes, coronary artery disease, chronic obstructive pulmonary disease, or heart failure (four measures).

(2) Measures within each domain are equally weighted.

[77 FR 69368, Nov. 16, 2012, as amended at 78 FR 74821, Dec. 10, 2013]

§ 414.1265 Reliability of measures.

To calculate a composite score for a quality measure or a cost measure, a group or solo practitioner subject to the value-based payment modifier must have 20 or more cases for that measure.

(a) In a performance period, if a group or solo practitioner has fewer than 20 cases for a measure, that measure is excluded from its domain and the remaining measures in the domain are given equal weight.

(1) Starting with the CY 2017 payment adjustment period, the exception to this paragraph (a) is the all-cause hospital readmissions measure described at § 414.1230(c). In a performance period, if a group has fewer than 200 cases for this all-cause hospital readmissions measure, that measure is excluded from its domain and the remaining measures in the domain are given equal weight.

(2) Starting with the CY 2017 payment adjustment period, the Medicare Spending Per Beneficiary measure described at § 414.1235(a)(6) is an exception to this paragraph (a). In a performance period, if a group or a solo practitioner

42 CFR Ch. IV (10–1–23 Edition)

has fewer than 125 episodes for this MSPB measure, that measure is excluded from its domain and the remaining measures in the domain are given equal weight.

(b)(1) For the CY 2015 payment adjustment period, if a reliable quality of care composite or cost composite cannot be calculated, payments will not be adjusted under the value-based payment modifier.

(2) Beginning with the CY 2016 payment adjustment period, a group and a solo practitioner subject to the value-based payment modifier will receive a quality composite score that is classified as “average” under § 414.1275(b)(1) if such group and solo practitioner do not have at least one quality measure that meets the minimum number of cases under paragraph (a) of this section.

(3) Beginning with the CY 2016 payment adjustment period, a group and a solo practitioner subject to the value-based payment modifier will receive a cost composite score that is classified as “average” under § 414.1275(b)(2) if such group and solo practitioner do not have at least one cost measure that meets the minimum number of cases under paragraph (a) of this section.

[77 FR 69368, Nov. 16, 2012, as amended at 79 FR 68007, Nov. 13, 2014; 80 FR 71384, Nov. 16, 2015]

§ 414.1270 Determination and calculation of Value-Based Payment Modifier adjustments.

(a) For the CY 2015 payment adjustment period:

(1) *Downward payment adjustments.* A downward payment adjustment will be applied to a group of physicians subject to the value-based payment modifier if—

(i) Such group neither self-nominates for the PQRS GPRO and reports at least one measure, nor elects the PQRS administrative claims option for CY 2013 as defined in § 414.90(h).

(A) Such adjustment will be –1.0 percent.

(B) [Reserved]

(ii) Such group elects that its value-based payment modifier be calculated using a quality-tiering approach, and is determined to have poor performance