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(4) If at least fifty percent of the eligible professionals in the group meet the criteria as individuals to avoid the PQRS payment adjustment for CY 2017 as specified by CMS, and all of those eligible professionals use a qualified clinical data registry and CMS is unable to receive quality performance data for them, the quality composite score for such group will be classified as “average” under § 414.1275(b)(1).

(d) For the CY 2018 payment adjustment period:

(1) A downward payment adjustment of –1.0 percent will be applied to a solo practitioner, a group with two to nine eligible professionals, and a group consisting only of nonphysician eligible professionals subject to the value-based payment modifier and no physicians; and a downward payment adjustment of –2.0 percent will be applied to a group with 10 or more eligible professionals and at least one physician if, during the applicable performance period as defined in § 414.1215, the following apply:

(i) For groups:

(A) Such group does not meet the criteria as a group to avoid the PQRS payment adjustment for CY 2018 as specified by CMS; and

(B) Fifty percent of the eligible professionals in such group do not meet the criteria as individuals to avoid the PQRS payment adjustment for CY 2018 as specified by CMS.

(ii) For solo practitioners, such solo practitioner does not meet the criteria as an individual to avoid the PQRS payment adjustment for CY 2018 as specified by CMS.

(2) For a group composed of 10 or more eligible professionals that is not included in paragraph (d)(1) of this section, the value-based payment modifier adjustment will be equal to the amount determined under § 414.1275(c)(4)(i).

(3) For a group composed of between two to nine eligible professionals and a solo practitioner that are not included in paragraph (d)(1) of this section, the value-based payment modifier adjustment will be equal to the amount determined under § 414.1275(c)(4)(ii).

(4) For a group and a solo practitioner consisting of nonphysician eligible professionals that are not included in paragraph (d)(1) of this section, the value-based payment modifier adjustment will be equal to the amount determined under § 414.1275(c)(4)(iii).

(5) If at least 50 percent of the eligible professionals in the group meet the criteria as individuals to avoid the PQRS payment adjustment for CY 2018 as specified by CMS, and all of those eligible professionals use a qualified clinical data registry and CMS is unable to receive quality performance data for them, the quality composite score for such group will be classified as “average” under § 414.1275(b)(1).

[78 FR 74821, Dec. 10, 2013, as amended at 79 FR 68007, Nov. 13, 2014; 80 FR 71384, Nov. 16, 2015; 82 FR 53363, Nov. 15, 2017]

§ 414.1275 Value-based payment modifier quality-tiering scoring methodology.

(a) The value-based payment modifier amount for a group and a solo practitioner subject to the value-based payment modifier is based upon a comparison of the composite of quality of care measures and a composite of cost measures.

(b) Quality composite and cost composite are classified into high, average, and low categories based on whether the composites are statistically above, not different from, or below the mean composite scores.

(1) Quality composites that are one or more standard deviations above the mean are classified into the high category. Quality composites that are one or more standard deviations below the mean are classified into the low category.

(2) Cost composites that are one or more standard deviations below the mean are classified into the low category. Cost composites that are one or more standard deviations above the mean are classified into the high category.

(c)(1) The following value-based payment modifier percentages apply to the CY 2015 payment adjustment period:

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CY 2015 VALUE-BASED PAYMENT MODIFIER AMOUNTS FOR THE QUALITY-TIERING APPROACH

Quality/cost	Low cost	Average cost	High cost (percent)
High quality	+ 2.0x*	+ 1.0x*	+ 0.0
Average quality	+ 1.0x*	+ 0.0%	-0.5
Low quality	+ 0.0%	-0.5%	-1.0

* Groups of physicians eligible for an additional + 1.0x if (1) reporting Physician Quality Reporting System quality measures through the GPRO web-interface or CMS-qualified registry, and (2) average beneficiary risk score is in the top 25 percent of all beneficiary risk scores.

(2) The following value-based payment modifier percentages apply to the CY 2016 payment adjustment period:

CY 2016 VALUE-BASED PAYMENT MODIFIER AMOUNTS FOR THE QUALITY-TIERING APPROACH

Quality/cost	Low cost	Average cost	High cost (percent)
High quality	+ 2.0x*	+ 1.0x*	+ 0.0
Average quality	+ 1.0x*	+ 0.0%	-1.0
Low quality	+ 0.0%	-1.0%	-2.0

* Groups of physicians eligible for an additional + 1.0x if reporting Physician Quality Reporting System quality measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores.

(3) The following value-based payment modifier percentages apply to the CY 2017 payment adjustment period:

(i) For groups with 10 or more eligible professionals:

CY 2017 VALUE-BASED PAYMENT MODIFIER AMOUNTS FOR THE QUALITY-TIERING APPROACH FOR GROUPS WITH 10 OR MORE ELIGIBLE PROFESSIONALS

Cost/quality	Low quality	Average quality	High quality
Low Cost	+ 0.0%	* + 2.0x	* + 4.0x
Average Cost	- 2.0%	+ 0.0%	* + 2.0x
High Cost	- 4.0%	- 2.0%	+ 0.0%

* Groups eligible for an additional + 1.0x if reporting Physician Quality Reporting System quality measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores, where 'x' represents the upward payment adjustment factor.

(ii) For groups with two to nine eligible professionals and solo practitioners:

CY 2017 VALUE-BASED PAYMENT MODIFIER AMOUNTS FOR THE QUALITY-TIERING APPROACH FOR GROUPS WITH TWO TO NINE ELIGIBLE PROFESSIONALS AND SOLO PRACTITIONERS

Cost/quality	Low quality	Average quality	High quality
Low Cost	+ 0.0%	* + 1.0x	* + 2.0x
Average Cost	+ 0.0%	+ 0.0%	* + 1.0x
High Cost	+ 0.0%	+ 0.0%	+ 0.0%

* Groups and solo practitioners eligible for an additional + 1.0x if reporting Physician Quality Reporting System quality measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores, where 'x' represents the upward payment adjustment factor.

(4) The following value-based payment modifier percentages apply to the CY 2018 payment adjustment period, for physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists who are solo practitioners or who are in groups of any size:

CY 2018 VALUE-BASED PAYMENT MODIFIER AMOUNTS FOR THE QUALITY-TIERING APPROACH FOR PHYSICIANS, PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, AND CERTIFIED REGISTERED NURSE ANESTHETISTS

Cost/quality	Low quality	Average quality	High quality
Low Cost	+0.0%	* +1.0x	* +2.0x

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CY 2018 VALUE-BASED PAYMENT MODIFIER AMOUNTS FOR THE QUALITY-TIERING APPROACH FOR PHYSICIANS, PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, AND CERTIFIED REGISTERED NURSE ANESTHETISTS—Continued

Cost/quality	Low quality	Average quality	High quality
Average Cost	+0.0%	+0.0%	*+1.0x
High Cost	+0.0%	+0.0%	+0.0%

* Eligible for an additional +1.0x if reporting Physician Quality Reporting System quality measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores, where 'x' represents the upward payment adjustment factor.

(d)(1) Groups of physicians subject to the value-based payment modifier that have an attributed beneficiary population with an average risk score in the top 25 percent of the risk scores of beneficiaries nationwide and for the CY 2015 payment adjustment period elect the quality-tiering approach or for the CY 2016 payment adjustment period are subject to the quality-tiering approach, receive a greater upward payment adjustment as follows:

(i) Classified as high quality/low cost receive an upward adjustment of + 3x (rather than + 2x); and

(ii) Classified as either high quality/average cost or average quality/low cost receive an upward adjustment of + 2x (rather than + 1x).

(2) Groups and solo practitioners subject to the value-based payment modifier that have an attributed beneficiary population with an average risk score in the top 25 percent of the risk scores of beneficiaries nationwide and for the CY 2017 payment adjustment period are subject to the quality-tiering approach, receive a greater upward payment adjustment as follows:

(i) Classified as high quality/low cost receive an upward adjustment of + 5x (rather than + 4x) if the group has 10 or more eligible professionals or + 3x (rather than + 2x) if a solo practitioner or the group has two to nine eligible professionals; and

(ii) Classified as either high quality/average cost or average quality/low cost receive an upward adjustment of + 3x (rather than + 2x) if the group has 10 or more eligible professionals or + 2x (rather than + 1x) if a solo practitioner or the group has two to nine eligible professionals.

(3) Groups and solo practitioners subject to the value-based payment modifier that have an attributed beneficiary population with an average risk score

in the top 25 percent of the risk scores of beneficiaries nationwide and for the CY 2018 payment adjustment period are subject to the quality-tiering approach, receive a greater upward payment adjustment as follows:

(i) Classified as high quality/low cost receive an upward adjustment of +3x (rather than +2x); and

(ii) Classified as either high quality/average cost or average quality/low cost receive an upward adjustment of +2x (rather than +1x).

[77 FR 69368, Nov. 16, 2012, as amended at 78 FR 74822, Dec. 10, 2013; 79 FR 68008, Nov. 13, 2014; 80 FR 71385, Nov. 16, 2015; 82 FR 53363, Nov. 15, 2017]

§ 414.1280 Limitation on review.

(a) There shall be no administrative or judicial review under section 1869 of the Act, section 1878 of the Act, or otherwise of all of the following:

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

(2) The evaluation of the quality of care composite, including the establishment of appropriate measure of the quality of care.

(3) The evaluation of costs composite, including establishment of appropriate measures of costs.

(4) The dates of implementation of the value-based payment modifier.

(5) The specification of the initial performance period and any other performance period.

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

(7) The determination of costs.

(b) [Reserved]

§ 414.1285 Informal inquiry process.

After the dissemination of the annual Physician Feedback reports, a group and a solo practitioner may contact CMS to inquire about its report and