

§ 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.

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