

§ 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. Begin-

ning 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