

Centers for Medicare & Medicaid Services, HHS

§414.1285

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
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

§ 414.1300

CMS to inquire about its report and the calculation of the value-based payment modifier.

[77 FR 69368, Nov. 16, 2012, as amended at 79 FR 68008, Nov. 13, 2014]

Subpart O—Merit-Based Incentive Payment System and Alternative Payment Model Incentive

SOURCE: 81 FR 77537, Nov. 4, 2016, unless otherwise noted.

§ 414.1300 Basis and scope.

(a) *Basis.* This subpart implements the following provisions of the Act:

(1) Section 1833(z)—Incentive Payments for Participation in Eligible Alternative Payment Models.

(2) Section 1848(k)—Quality Reporting System.

(3) Section 1848(m)—Incentive Payments for Quality Reporting.

(4) Section 1848(q)—Merit-based Incentive Payment System.

(b) *Scope.* This subpart part sets forth the following:

(1) The circumstances under which eligible clinicians are not considered MIPS eligible clinicians with respect to a year.

(2) How individual MIPS eligible clinicians can have their performance assessed as a group.

(3) The data submission methods and data submission criteria for each of the MIPS performance categories.

(4) Methods for calculating a performance category score for each of the MIPS performance categories.

(5) Methods for calculating a MIPS final score and applying the MIPS payment adjustment to MIPS eligible clinicians.

(6) Requirements for an APM to be designated an “Advanced APM.”

(7) Methods for eligible clinicians and entities participating in Advanced APMs to meet the participation thresholds to become Qualifying APM Participants (QPs) and Partial QPs.

(8) Methods and processes for counting participation in Other Payer Advanced APMs in making QP and Partial QP determinations.

42 CFR Ch. IV (10–1–24 Edition)

(9) Methods for calculating and paying the APM Incentive Payment to QPs.

(10) Criteria for Physician-Focused Payment Models (PFPs).

[81 FR 77537, Nov. 4, 2016, as amended at 86 FR 65669, Nov. 19, 2021]

§ 414.1305 Definitions.

As used in this section, unless otherwise indicated—

Additional performance threshold means the numerical threshold for a MIPS payment year against which the final scores of MIPS eligible clinicians are compared to determine the additional MIPS payment adjustment factors for exceptional performance.

Advanced Alternative Payment Model (Advanced APM) means an APM that CMS determines meets the criteria set forth in § 414.1415.

Affiliated practitioner means an eligible clinician identified by a unique APM participant identifier on a CMS-maintained list who has a contractual relationship with the APM Entity for the purposes of supporting the APM Entity’s quality or cost goals under the Advanced APM.

Affiliated practitioner list means the list of Affiliated Practitioners of an APM Entity that is compiled from a CMS-maintained list.

Aligned Other Payer Medical Home Model means an aligned other payer payment arrangement (not including a Medicaid payment arrangement) operated by a payer formally partnering in a CMS Multi-Payer Model that is a Medical Home Model through a written expression of alignment and cooperation, such as a memorandum of understanding (MOU) with CMS, and is determined by CMS to have the following characteristics:

(1) The other payer payment arrangement has a primary care focus with participants that primarily include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, primary care focus means the inclusion of specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine;