under part 414 subparts D and F for the item or the single payment amount established under the DMEPOS competitive bidding program provided that payment for such item is not included in the payment amount for other CORF services paid under paragraphs (a) or (d).

(d) *Payment for drugs and biologicals.* Drugs and biologicals that are CORF services under §410.100(j) of this chapter, are paid the lesser of 80 percent of the following:

(1) The actual charge for the service provided that payment for such item is not included in the payment amount for other CORF services paid under paragraphs (a) or (c); or

(2) The amount determined using the same methodology for drugs (as defined in §414.704 of this chapter) described in section 1842(o)(1) of the Act provided that payment for such *drug* is not included in the payment amount for other CORF services paid under paragraphs (a) or (c).

(e) *Payment for CORF services when no fee schedule amount for the service.* If there is no fee schedule amount established for a CORF service, payment for the item or service will be the lesser of 80 percent of:

(i) The actual charge for the service provided that payment for such item or service is not included in the payment amount for other CORF services paid under paragraphs (a), (c), or (d) of this section.

(ii) The amount determined under the fee schedule established for a comparable service as specified by the Secretary provided that payment for such item or service is not included in the payment amount for other CORF services paid under paragraphs (a), (c), or (d) of this section.

Subpart N—Value-Based Payment Modifier Under the Physician Fee Schedule

SOURCE: 77 FR 69368, Nov. 16, 2012, unless otherwise noted.

§414.1200 Basis and scope.

(a) *Basis.* This subpart implements section 1848(p) of the Act by establishing a payment modifier that provides for differential payment starting in 2015 to a group of physicians under the Medicare physician fee schedule based on the quality of care furnished compared to cost during a performance period.

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

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

(2) Performance and payment adjustment periods.

(3) Reporting mechanisms for the value-based payment modifier.

(4) Alignment of PQRS quality of care measures with the quality measures for the value-based payment modifier.

(5) Additional measures for groups of physicians.

(6) Cost measures.

(7) Attribution for quality of care and cost measures.

(8) Scoring methods for the value-based payment modifier.

(9) Benchmarks for quality of care measures.

(10) Benchmarks for cost measures.

(11) Composite scores.

(12) Reliability of measures.

(13) Payment adjustments.

(14) Value-based payment modifier quality-tiering scoring methodology.

(15) Limitation of review.

(16) Inquiry process.

§414.1205 Definitions.

As used in this subpart, unless otherwise indicated—

Accountable care organization (ACO) has the same meaning given this term under §425.20 of this chapter.

Critical access hospital has the same meaning given this term under §400.202 of this chapter.

Electronic health record (EHR) has the same meaning given this term under §414.92 of this chapter.

Eligible professional has the same meaning given this term under section 1848(k)(3)(B) of the Act.

Federally Qualified Health Center has the same meaning given this term under §405.2401(b) of this chapter.

Group of physicians means a single Tax Identification Number (TIN) with 2

or more eligible professionals, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN.

Performance period means the calendar year that will be used to assess the quality of care furnished compared to cost.

Performance rate mean the calculated rate for each quality or cost measure such as the percent of times that a particular clinical quality action was reported as being performed, or a particular outcome was attained, for the applicable persons to whom a measure applies as described in the denominator for the measure.

Physician has the same meaning given this term under section 1861(r) of the Act.

Physician Fee Schedule has the same meaning given this term under part 410 of this chapter.

Physician Quality Reporting System means the system established under section 1848(k) of the Act.

Risk score means the beneficiary risk score derived from the CMS Hierarchical Condition Categories (HCC) model.

Taxpayer Identification Number (TIN) has the same meaning given this term under § 425.20 of this chapter.

Value-based payment modifier means the percentage as determined under § 414.1270 by which amounts paid to a physician or group of physicians under the Medicare physician fee schedule established under section 1848 of the Act are adjusted based upon a comparison of the quality of care furnished to cost as determined by this subpart.

§ 414.1210 Application of the value-based payment modifier.

(a) The value-based payment modifier is applicable to physicians:

(1) For CY 2015, in groups with 100 or more eligible professionals based on the performance period described at § 414.1215(a).

(2) [Reserved]

(b) *Exceptions.* (1) Groups of physicians that are participating in the Medicare Shared Savings Program, the testing of the Pioneer ACO model, or other similar Innovation Center or CMS initiatives shall not be subject to any adjustments under the value-based payment modifier for CY 2015 and CY 2016.

(2) [Reserved]

(c) *Group size determination.* Identification of the groups of physicians subject to the value-based payment modifier is based on a query of PECOS on October 15, 2013. Groups of physicians are removed from this October 15 list if, based on a claims analysis, the group of physicians did not have 100 or more eligible professionals that submitted claims during the performance period.

§ 414.1215 Performance and payment adjustment periods for the value-based payment modifier.

(a) The performance period is calendar year 2013 for value-based payment modifier adjustments made in the calendar year 2015 payment adjustment period.

(b) The performance period is calendar year 2014 for value-based payment modifier adjustments made in the calendar year 2016 payment adjustment period.

§ 414.1220 Reporting mechanisms for the value-based payment modifier.

Groups of physicians subject to the value-based payment modifier may submit data on quality measures as specified under the Physician Quality Reporting System and in § 414.90(g) for which they are eligible and § 414.90(h)(3)(vi) administrative claims.

§ 414.1225 Alignment of Physician Quality Reporting System quality measures and quality measures for the value-based payment modifier.

All of the quality measures for which groups of physicians are eligible to report under the Physician Quality Reporting System starting in CY 2013 are used to calculate the value-based payment modifier program to the extent the group of physicians submits data on such measures.

§ 414.1230 Additional measures for groups of physicians.

The value-based payment modifier includes the following additional quality measures for all groups of physicians subject to the value-based payment modifier: