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(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 re- signed 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.  

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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:  
(1) For the CY 2015 payment adjustment period, to physicians in groups with 100 or more eligible professionals based on the performance period described at §414.1215(a).  
(2) For the CY 2016 payment adjustment period, to physicians in groups with 10 or more eligible professionals based on the performance period described at §414.1215(b).  
(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. The list of groups of physicians subject to the value-based payment modifier for the CY 2015 payment adjustment period is based on a query of PECOS on October 15, 2013. For each subsequent calendar year payment adjustment period, the list of groups of physicians subject to the value-based payment modifier is based on a query of PECOS that occurs within 10 days of the close of the Physician Quality Reporting System group registration process during the applicable performance period described at §414.1215. Groups of physicians are removed from the PECOS-generated list if, based on a claims analysis, the group of physicians did not have the required number of eligible professionals, as defined in §414.1210(a), 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.

(c) The performance period is calendar year 2015 for value-based payment modifier adjustments made in the calendar year 2017 payment adjustment period.

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

Groups of physicians subject to the value-based payment modifier (or individual eligible professionals within such groups) may submit data on quality measures as specified under the Physician Quality Reporting System using the reporting mechanisms for which they are eligible.

§ 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 or individual eligible professionals are eligible to report under the Physician Quality Reporting System in a given calendar year are used to calculate the value-based payment modifier for the applicable payment adjustment period, as defined in §414.1215, to the extent a group of physicians or individual eligible professionals within such group 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:


(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.

§ 414.1235 Cost measures.

(a) Included measures. Beginning with the CY 2016 payment adjustment period, costs for groups of physicians 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