

**Merit-based Incentive Payment System (MIPS):  
Episode-Based Cost Measure Field Test Reports  
Frequently Asked Questions (FAQs)**

October 2017

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This document provides a comprehensive set of question and answers related to the field testing of eight episode-based cost measures. It includes all of the questions and answers provided in the accompanying Fact Sheet also posted on the [CMS MACRA page](#), as well as responses to additional questions about field testing and the episode-based cost measures.

## 1.0 Policy Context

### 1.1 What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established the Quality Payment Program, a new way to pay clinicians.

Under the Quality Payment Program, clinicians are rewarded for giving high-quality and high value care through Advanced Alternate Payment Models (APMs) or the Merit-based Incentive Payment System (MIPS). Clinicians participating in MIPS will earn a performance-based payment adjustment to their Medicare payment. This payment adjustment is based on a MIPS final score that assesses evidence-based and practice-specific quality data in the following categories:

1. Quality
2. Improvement activities
3. Advancing care information
4. Cost

The MIPS cost performance category will be calculated in 2017, but will not be used to determine payment adjustment. That is, the cost performance category of the MIPS final score is weighted at zero percent for the 2017 performance year; it also is proposed to continue to be weighted at zero percent of the MIPS final score for the 2018 performance year.

As required by MACRA, the MIPS cost performance category will be weighted at 30 percent of the MIPS final score for the 2019 performance year meaning that it will affect payment in the 2021 payment year.

### 1.2 How do the episode-based cost measures in field testing relate to the Quality Payment Program?

MACRA established a process to enhance the infrastructure for resource use measurement, including for the purpose of developing cost measures for the MIPS cost performance category. MACRA requires cost measures implemented in MIPS to include consideration of patient condition groups and care episode groups (referred to as “episode groups”). As a result, eight episode-based cost measures are currently under development and are being field tested.

These 8 measures are being developed with extensive input from 7 Clinical Subcommittees (CS), a Technical Expert Panel, and public comment:

- Elective Outpatient Percutaneous Coronary Intervention (PCI)
- Knee Arthroplasty
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia
- Routine Cataract Removal with Intraocular Lens (IOL) Implantation
- Screening/Surveillance Colonoscopy
- Intracranial Hemorrhage or Cerebral Infarction
- Simple Pneumonia with Hospitalization
- ST-Elevation Myocardial Infarction (STEMI) with PCI

More information on episode-based cost measures can be found in answers to the questions in Section 2 below.

### **1.3 When will these episode-based measures be used in MIPS?**

The eight episode-based measures currently being field tested and are **not** included in the 2017 or 2018 MIPS performance years. These measures are being field tested before consideration of their potential use in the MIPS cost performance category in a future year. As part of this field testing, CMS and Acumen are now seeking stakeholder feedback on the draft measure specifications for the eight measures in their current stage of development, the Field Test Report template, and all accompanying documentation. This feedback will be considered in refining the measures and for future measure development activities.

CMS will consider stakeholder feedback, public comments, measure refinements, and Measure Applications Partnership recommendations before considering the potential use of these eight episode-based cost measures in the MIPS cost performance category for future years. This would involve proposing the measures for use in MIPS as part of the notice-and-comment rulemaking process.

### **1.4 How do these cost measures relate to other measures in the MIPS cost performance category?**

These episode-based cost measures are currently under development and have not yet been proposed for use in the Quality Payment Program. They are being reported to clinicians currently as a part of field testing to gather stakeholder feedback on the measures to inform refinements before consideration of their potential use in the Quality Payment Program.

Two other cost measures, the Medicare Spending Per Beneficiary (MSPB) measure for clinicians and the Total Per Capita Cost (TPCC) measure, have been finalized for use in the 2017 MIPS performance period and proposed for continued inclusion in the 2018 performance period through the CY 2018 Quality Payment Program Proposed Rule. However, as mentioned above, the weighting of the cost performance category will be zero percent in 2017 and has also been proposed to remain at zero percent for the 2018 performance period.

The MSPB and TPCC measures have been reported to clinicians previously through the Quality and Resource Use Reports (QRURs), including reports on those measures that were released on September 18, 2017. The field testing of the new episode-based cost measures is separate from these measures reported in the QRURs. Clinicians who do not receive field testing reports for any of the 8 episode-based cost measures under development may receive QRURs containing their MSPB or TPCC cost measure performance.

### **1.5 Why are these episode-based cost measures being field tested now?**

Through field testing, CMS and Acumen are looking for voluntary feedback on 8 episode-based cost measures and the measure reporting format. We will use this feedback to determine whether these measures should be considered for potential use in the Quality Payment Program, and how the measures and reporting format should be improved to provide clinicians actionable information to ensure high quality and high value care. Field testing also serves as

an opportunity for clinicians to learn about and gain experience with episode-based cost measures before they are included in MIPS.

Specifically, we are looking for feedback on the following types of questions:

- Does the information presented on the measure in the field test report and accompanying documentation help you identify actionable improvements to patient care and to cost efficiency?
- Are the measure specifications for the 8 episode-based cost measures clinically valid? Measure specifications include episode triggers, attribution, assigned services, episode windows, and risk adjustment.
- How can the information be presented in such a way that it is most useful for quality improvement?
- How understandable is the measure documentation provided, and what portions of the documentation could be clearer or more detailed?
- Would any additional documents or information be useful to help clinicians and other stakeholders understand these measures?

## 2.0 Field Testing

### 2.1 How does field testing work?

Field testing is a voluntary opportunity for affected clinicians and other stakeholders to provide feedback on the measure specifications and the report template. We will be testing the 8 measures in their current stage of development to get clinician and stakeholder feedback on the draft measure specifications and report template by:

- Posting confidential clinician feedback reports for certain group practices and solo practitioners on the [CMS Enterprise Portal](#). See further detail on who is likely to receive a Field Test Report in the next question and answer.
- Posting a mock report, draft measure specifications, and related documentation on the [CMS MACRA page](#).

### 2.2 Who will receive a Field Test Report?

Clinicians likely to get a report on the [CMS Enterprise Portal](#) are those who:

- perform the procedures (for procedural episode groups) or manage hospitalizations for conditions (for acute inpatient medical conditions episode groups) for one or more of the 8 measures above are likely to get a report.
- are attributed 10 or more episodes during the measurement period (June 1, 2016 to May 31, 2017) to get a report.

Field Test Reports are available at the clinician group practice and solo practitioner level. For clinician group practices, the group practice must be attributed at least 10 or more episodes across all clinicians billing the group practice. For solo practitioners, the clinician must be attributed at least 10 or more episodes. Please see the next question and answer for more details about how to access the reports.

Clinicians who do not meet the criteria listed above will not receive a report. We encourage clinicians who don't receive a report and all other stakeholders to review and comment on the mock report, draft measure specifications, and related documentation.

## 2.3 How can group practices and solo practitioners access their Field Test Report(s)?

Clinicians or clinician group's authorized representatives can access the Cost Measure Field Test Report(s) at <https://portal.cms.gov> using an Enterprise Identity Management (EIDM) account with one of the following roles in the **Physician Quality and Value Programs** application:

- Groups are identified in the EIDM by their Medicare billing Taxpayer Identification Number (TIN). A group consists of **two or more eligible clinicians** (as identified by their National Provider Identifier [NPI] that bill under the same TIN), and will receive a report if the TIN is attributed at least 10 or more episodes among all NPIs billing under the TIN. A group can have either of the following roles:
  - Security Official
  - Group Representative
- The group-level users (i.e., Security Official and Group Representative) have access to the group practice's reports and the individual-level reports for the solo practitioners within the group practice.
- An individual eligible clinician (or a solo practitioner) is identified by a single NPI that bills under the TIN, and will receive a report if the NPI is attributed at least 10 or more episodes. A solo practitioner can have either of the following roles:
  - Individual Practitioner
  - Individual Practitioner Representative

Clinicians can get ready to access their reports by signing up for a new EIDM account using [this EIDM user guide](#), or by making sure existing EIDM accounts have the 'Physician Quality and Value Programs' role using [this existing EIDM user guide](#).

## 2.4 When is field testing for these episode-based cost measures?

Field testing starts on Monday, October 16, 2017 and ends on November 15, 2017. During this period, stakeholders may submit feedback on the measures through the process outlined in the next question and answer.

## 2.5 How can I give feedback on episode-based cost measures?

All stakeholders can send us feedback on the measures, documentation, and report presentation through this [online survey](#) between October 16 and November 15, 2017. Comments may be submitted through this [online survey](#), and stakeholders can attach a PDF or Word document with their comments. Comments may be submitted anonymously if preferred. If you have questions or want more information, please send us an email at [QPPCostMeasureTesting@ketchum.com](mailto:QPPCostMeasureTesting@ketchum.com).

## 2.6 What data was used for the Field Test Reports?

Episodes are constructed and measures are calculated using the following data:

- Medicare Parts A and B claims data from the Common Working File (CWF)
- Enrollment Data Base (EDB)
- Long Term Care Minimum Data Set (LTC MDS)
- Provider Enrollment, Chain and Ownership System (PECOS)

The measurement period for the MACRA Episode-Based Cost Measure Field Test Reports is June 1, 2016, through May 31, 2017.

## **2.7 How can group practices and solo practitioners use the data in their Field Test Report(s)?**

Group practices and solo practitioners may use the data in their Field Test Report(s) to understand what contributes to the costs of their patients' care and identify areas to improve efficiency and care coordination.

The tables and figures in the report are intended to show:

- How clinician cost measure performance varies by different episode sub-groups.
- Which other Medicare providers account for patient costs during the episode.
- What types of services make up a large or small share of episode costs.

Please reference Appendix C of the Field Test Report, "How to Interpret this Report," for more information about how to use and interpret the report.

## **2.8 How can my TIN or I get help to interpret my cost measure score?**

For assistance in interpreting your cost measure score, Field Test Reports contain an Appendix C titled "How to Interpret this Report" which can help to explain how to navigate the reports. The additional materials listed in question 1.10 can also assist in interpreting a cost measure score.

For all other questions and further assistance in interpreting your cost measure score, please [click here to email us](#).

## **2.9 Can I still give provide feedback on the measures even if I didn't receive a report?**

Not all clinicians will receive a confidential Field Test Report because of the clinical scope and attribution method for the 8 episode-based cost measures. Even if you do not get a Field Test Report, we encourage you to review and comment on the publicly available materials starting on October 16, 2017, when they become available on the [CMS MACRA page](#):

- Draft Cost Measure Methodology for each measure
- Measure Code Lists file with specifications for each measure
- Mock field test report
- Fact Sheet with an overview of field testing
- Frequently Asked Questions (this document)

## 3.0 Episode-Based Cost Measures

### 3.1 What are episode-based cost measures?

Episode-based cost measures represent the cost to Medicare for the items and services furnished to a patient during an episode of care (“episode”). Episode-based cost measures are developed to let clinicians know the cost of the care they are responsible for providing to a beneficiary during the episode’s timeframe. In the Field Test Reports and their documentation, the term “cost” means the amount Medicare pays on traditional, fee-for-service claims.<sup>1</sup>

Episode-based cost measures are calculated with Medicare Parts A and B fee-for-service claims data and are based on *episode groups*. Episode groups:

- Represent a clinically cohesive set of medical services rendered to treat a given medical condition.
- Aggregate all items and services provided for a defined patient cohort to assess the total cost of care.
- Are defined around treatment for a condition (i.e., acute inpatient or chronic) or performance of a procedure.

Services in the episode group could be treatment services, diagnostic services, and ancillary items and services directly related to treatment (such as anesthesia for a surgical procedure). They can also be services that happen after the initial treatment period that may be given to patients as follow-up care or to treat complications resulting from the treatment.

An *episode* is a specific instance of an episode group for a given patient and clinician. For example, in a given year, a clinician might be attributed 20 episodes (instances of the episode group) from the episode group for heart failure.

To make sure there is a more accurate comparison of cost across clinicians, episode costs are payment standardized and risk adjusted.

- **Payment standardization** adjusts the allowed amount for a Medicare service to facilitate cost comparisons and limit observed differences in costs to those that may result from health care delivery choices. Payment standardized costs remove any Medicare payment differences due to adjustments for geographic differences in wage levels or policy-driven payment adjustments such as those for teaching hospitals.
- **Risk adjustment** accounts for patient characteristics that can influence spending and are outside of clinician control. For example, for the elective outpatient PCI episode-based cost measure, the risk adjustment model may account for a patient’s history of heart failure.

### 3.2 What are the types of episode groups?

These are the 3 types of episode groups on which cost measures can be based:

- **Procedural** episode groups focus on procedures of a defined purpose or type, such as surgeries. Of the 8 measures in field testing, 5 of these measures are based on procedural episode groups: Elective Outpatient PCI, Knee Arthroplasty, Revascularization for Lower Extremity Chronic Critical Limb Ischemia, Routine Cataract Removal with IOL Implantation, and Screening/Surveillance Colonoscopy.

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<sup>1</sup> Specifically, cost is defined by allowed amounts on Medicare claims data, which include both Medicare trust fund payments and beneficiary deductible and coinsurance.

- **Acute inpatient medical condition** episode groups represent treatment for self-limited acute illness or treatment for flares or an exacerbation of a condition that requires a hospital stay. Of the 8 measures in field testing, 3 of these measures are based on acute inpatient medical condition episode groups: Intracranial Hemorrhage or Cerebral Infarction, Simple Pneumonia with Hospitalization, and STEMI with PCI.
- **Chronic condition** episode groups account for the patient's clinical history at the time of a medical visit and their current health status. An example of a chronic condition episode group is an episode group for the ongoing management of a disease, such as diabetes.

We did not include chronic conditions when we first developed episode-based cost measures because there are unique challenges in creating rules for attribution and episode windows for conditions that need ongoing management. We worked with measure development contractor Acumen, LLC (referred to as “Acumen”) to develop these 8 episode-based cost measures. Acumen plans to call together a future Technical Expert Panel (TEP) focused on chronic condition episode groups. This TEP will give guidance on developing chronic condition episode groups.

### 3.3 How were the conditions and procedures for the 8 cost measures in field testing chosen?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a process to enhance the infrastructure for resource use measurement, including for purposes of developing cost measures for the Merit-based Incentive Payment System. The process of developing these measures has involved a series of steps required by MACRA whereby feedback has been solicited from stakeholders on a draft list of episode groups and episode trigger codes posted in December 2016.<sup>2</sup>

After evaluating stakeholder feedback, Acumen convened Clinical Subcommittees that used the following criteria to recommend the initial conditions and procedures for the 8 cost measures in field testing:

- (i) The potential impact on Medicare spending
- (ii) Clinical coherence in regards to representing a patient population that has a similar stage and severity of a particular illness or condition
- (iii) The measure’s opportunity for improvement
- (iv) The measure’s opportunity for alignment with established quality indicators

Specifically, Clinical Subcommittee members looked at factors like the volume of beneficiaries impacted by the condition or procedure, the share of cost to Medicare impacted by the condition or procedure, the number of clinicians/clinician groups attributed, and the potential for alignment with existing quality measures.

### 3.4 How are episodes attributed to a clinician?

After episodes are opened, or triggered, we figure out which clinician(s) to attribute the episode to using information from the trigger claims.

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<sup>2</sup> CMS, “Draft List of MACRA Episode Groups and Trigger Codes”, *MACRA Feedback Page*, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/draft-list-of-care-episode-and-patient-condition-groups-and-codes.zip>

- The attributed clinician is identified by unique Taxpayer Identification Number/National Provider Identifier (TIN-NPI) informed by the performing NPI field on the Physician/Supplier Part B (Carrier) claim.
- For procedural episode groups, episodes are attributed to the clinician(s) rendering the trigger services (HCPCS/CPT procedure codes).
  - For example, an orthopedic surgeon billing HCPCS/CPT code 27446 would be attributed a Knee Arthroplasty episode.
- For acute inpatient medical condition episode groups, episodes are attributed to the clinician(s) rendering at least 30 percent of inpatient evaluation and management (E&M) services during an inpatient hospitalization with the medical Medicare Severity Diagnosis-Related Groups (MS-DRGs) for the episode group.
  - For example, a neurologist billing 30 percent of inpatient E&M codes on Part B Physician/Supplier claims concurrent to an inpatient hospitalization with MS-DRG code 065 would be attributed an Intracranial Hemorrhage or Cerebral Infarction episode.

### 3.5 What services are included in an episode?

After episodes are attributed to one or more clinicians, service assignment indicates which services will be included in episode costs if they happen within a beneficiary's episode window. Clinical Subcommittee members gave their feedback on the services that should be included in episode costs based upon the clinical relevance of the services to the episode group. All assigned services are either assigned:

- (i) Because the service makes up the trigger event, or
- (ii) Because of a service assignment rule.

For services that are assigned because the service makes up the trigger event (listed as (i) above), the following describe how the rules are applied for each type of episode group:

- For procedural episodes, services are assigned if:
  - They are the triggering service on the trigger claim, or
  - They make up the trigger event (i.e., services including the triggering service on the trigger claim as well as the concurrent inpatient stay (if applicable) and its associated Part B physician/supplier and durable medical equipment services).
- For acute inpatient medical condition episode groups, services are assigned if they make up the episode trigger (i.e., services such as the inpatient E&M services and inpatient stay comprising the episode trigger as well as any other concurrent Part B Physician/Supplier and Durable Medical Equipment services during the stay).

For services that are assigned because of a service assignment rule (listed as (ii) above), we programmatically look at all other services that happen during the episode window to see if their costs are assigned to the episode based on the episode group's service assignment rules.

### 3.6 What is the purpose of risk adjustment?

We calculate risk-adjusted costs for each episode to try to get a more accurate cost comparison across clinicians by taking into account factors clinicians cannot control but that can affect spending. For example, risk adjustment takes into account factors like a beneficiary's:

- Illness severity
- Age
- Comorbidities

When we adjust for risk, we aim to isolate the variation in clinicians' costs to Medicare to the costs clinicians can reasonably control. Accounting for these factors is one way to make sure the cost measures are valid and guard against unintended consequences. In other words, risk adjustment helps facilitate more accurate comparisons across clinicians by accounting for differences in factors outside of a clinician's control (such as the clinical complexity of their beneficiaries).

### **3.7 What risk adjustment methodology was used?**

Risk-adjusted costs for each episode were calculated using two types of risk adjustors:

- Standard risk adjustors used commonly in risk adjustment for all of the episode-based cost measures. These standard risk adjustors include:
  - Factors included in the CMS Hierarchical Condition Category Version 22 (CMS-HCC V22) 2016 Risk Adjustment Model, and
  - Additional standard variables, such as beneficiary age and original reason for enrollment in Medicare
- Other risk adjustors recommended by each of the Clinical Subcommittees to include in each cost measure's risk adjustment model.

Detailed specifications (i.e., codes specifying each variable or sub-population) can be found in each measure-specific Draft Measure Code Lists file.

### **Where can I get more information about episode-based cost measures?**

If you have questions, email [QPPCostMeasureTesting@ketchum.com](mailto:QPPCostMeasureTesting@ketchum.com).