Quality Payment
PROGRAM

MERIT-BASED INCENTIVE PAYMENT SYSTEM

Participating in the **Cost** Performance Category in 2018 (Year 2)

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Hyperlinks

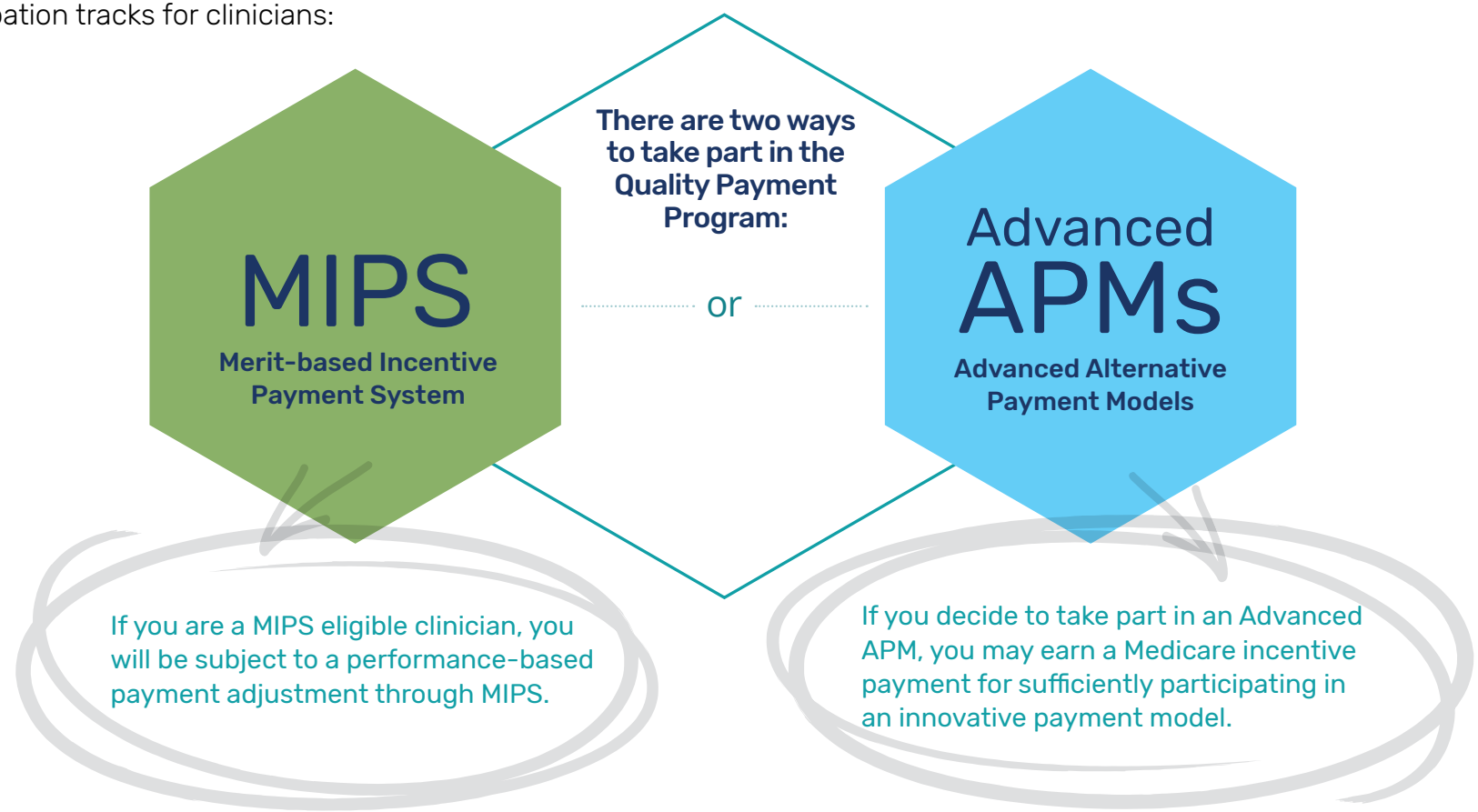
Hyperlinks to our Quality Payment Program website are included throughout this guide to direct you to more information and resources.

NOTE: *This guide was prepared as a general summary for informational purposes only, not intended to grant rights, impose obligations, or take the place of the written law. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.*

INTRODUCTION TO THE QUALITY PAYMENT PROGRAM

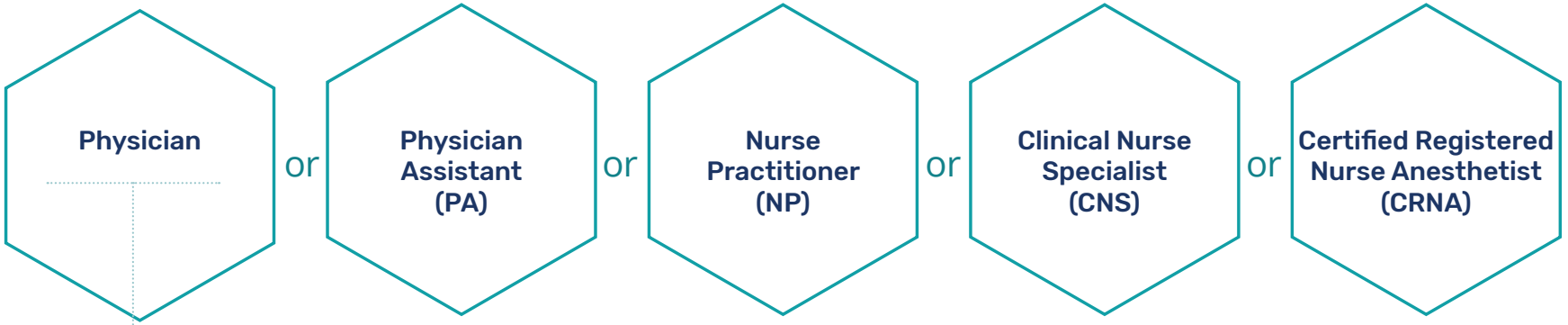
Introduction to the Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. By law, MACRA requires CMS to implement an incentive program, referred to as the Quality Payment Program, which provides two participation tracks for clinicians:



Who is a MIPS Eligible Clinician?

For the **2018 performance period**, you can participate in MIPS if you're a:



(which includes doctor of medicine, doctor of osteopathy, doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, doctor of optometry, and chiropractors[1])

- You can also participate as a group if the group includes at least one of the clinician types listed above.

[1] *With respect to certain specified treatment, a doctor of chiropractic must be legally authorized to practice by a State in which he/she performs this function.*

Who is Excluded from MIPS?

If you are a MIPS eligible clinician (as indicated by the clinician types on the previous page), you can still be excluded from participating in MIPS for the 2018 performance year if you:

Enrolled in Medicare for the first time in 2018

or

Participate in an Advanced APM and are determined to be a Qualifying APM Participant (QP)

or

Participate in an Advanced APM and are determined to be a Partial QP and do not elect to participate in MIPS

or

Do not exceed the low-volume threshold. (More information about this exclusion is provided in the next section.)

- If you're considered exempt from MIPS, then you do not have to participate in MIPS and you will not receive a MIPS payment adjustment in 2020.

Voluntary Participation in MIPS

If you're not eligible to participate in MIPS, you can participate voluntarily. Voluntary participation allows you to prepare for and become familiar with the program without receiving a payment adjustment (positive or negative). This may be helpful if you become eligible for MIPS in future years.

Participating in MIPS in 2018

There are two low-volume threshold determination periods for the 2018 performance year, during which CMS reviews both historical and performance period claims data.

Historical claims data:
September 1, 2016 – August 31, 2017

and

Performance period claims data:
September 1, 2017 – August 31, 2018

- The low-volume threshold is calculated at both the practice (Taxpayer Identification Number (TIN)) level and clinician (TIN-National Provider Identifier (NPI)) level. MIPS eligible clinicians who have reassigned billing rights to multiple practices will be evaluated for the low-volume threshold at each practice (under each TIN-NPI combination), which means you may be required to participate in MIPS at one practice but are excluded at another.

For the 2018 performance period, CMS updated the low-volume threshold; clinicians, groups and MIPS APM entities are excluded from MIPS if, during **either** determination period they:

Billed Medicare for **less than or equal to $90,000** in Medicare Part B allowed charges for covered professional services payable under the Medicare Physician Fee Schedule (PFS).

or

Provided care for **200 or fewer** Part B-enrolled Medicare FFS beneficiaries.

The low-volume threshold exclusion is applied at the level in which you will participate in MIPS.

- **If you participate as an individual (each MIPS eligible clinician submits their own individual data collected at the practice),** the low-volume threshold is applied at the individual level.
  - MIPS eligible clinicians who do not exceed the low-volume threshold as individuals are not required to submit individual data collected at this practice and will not receive a payment adjustment at this practice.
- **If you participate as a group (the practice submits aggregated data collected on behalf of all the MIPS eligible clinicians in the practice)**, the low-volume threshold is applied at the group level.
  - MIPS eligible clinicians who do not exceed the low-volume threshold as individuals will receive a payment adjustment at this practice based on the group's submission provided the group exceeds the low-volume threshold.
- **If you participate as a virtual group (the virtual group submits aggregated data collected on behalf of all the MIPS eligible clinicians in the virtual group)**, the low-volume threshold is applied at the virtual group level.
  - MIPS eligible clinicians who do not exceed the low-volume threshold as individuals will receive a payment adjustment at this practice based on the virtual group's submission. (The approval process requires that all virtual groups exceed the low-volume threshold.)
- **If you participate in a MIPS APM**, the low-volume threshold is calculated for the MIPS APM Entity, and is not applied at the individual or group level. MIPS eligible clinicians participating in a MIPS APM should work with their MIPS APM Entity to understand their data submission requirements.

TIP: Beginning with the 2018 performance year, the low-volume threshold calculations will be based on PFS allowed charges and the number of patients receiving covered PFS services.

For more information on the low-volume threshold and the two determination periods, please refer to the 2018 MIPS Participation and Overview Fact Sheet.

What are my Participation Options?

In 2018, if you're eligible for MIPS, you can participate in the following ways:

- **As an Individual Clinician**
- **As a Group**
- **As a Virtual Group** (new for 2018)
- **As a MIPS APM Entity***

**If you're in a specific type of APM called a MIPS APM, you will participate in MIPS through that APM and be scored using what is called the "APM scoring standard." Clinicians in a MIPS APM are awarded credit for activities performed within the APM; all clinicians in the same MIPS APM Entity receive the same score, based on the data submitted by or on behalf of the Entity.*

Can I Participate as an Individual and a Group?

Yes: MIPS eligible clinicians can submit data as an individual and as part of a group under the same TIN. In this instance, the clinician will be evaluated across all four MIPS performance categories on their individual performance and on the group's performance, with a final score calculated for each evaluation. The clinician will receive a payment adjustment based on the higher of the two scores.

To learn more about how to participate in MIPS:

- Visit the About MIPS Participation and Individual or Group Participation web pages on the Quality Payment Program website
- View the MIPS Participation and Overview Fact Sheet
- Check your participation status using the QPP Participation Status Tool

There are **four** performance categories under MIPS that affect future Medicare payments. Each performance category has a specific weight, and your performance in these categories contributes to your MIPS final score.

This guide focuses on the **Cost** performance category in 2018 (or "Year 2") of the Quality Payment Program.

MIPS performance category weights in 2018:

Cost

10% of MIPS Final Score in 2018

Quality

50% of MIPS Final Score

Improvement Activities

15% of MIPS Final Score

Promoting Interoperability

(formerly Advancing Care Information)

25% of MIPS Final Score

Please note that for MIPS APM participants, scored under the APM scoring standard, the performance categories have the following weights:

50%	Quality	**0%**	Cost	**20%**	Improvement Activities	**30%**	Promoting Interoperability *(formerly Advancing Care Information)*

COST BASICS

What is it?

The **Cost** performance category is an important part of MIPS. Although clinicians don't personally determine the price of individual services provided to Medicare beneficiaries, they can affect the amount and types of services that are provided to their patients. By better coordinating care and seeking to improve health outcomes by ensuring their patients receive the right services, clinicians play a meaningful role in delivering high quality care at a reasonable cost.

For the **2017 performance year**, CMS didn't score the Cost performance category, so Cost performance accounted for 0% of your 2017 MIPS Final Score.

For the **2018 performance year**, the MIPS Cost performance category:

- Has a maximum score of 100; AND
- Accounts for 10% of your 2018 MIPS Final Score

For the **2019**, **2020**, and **2021 performance years**:

- The MIPS Cost performance category weight will be between **10%** and **30%** as established by the Bipartisan Budget Act of 2018
- CMS will establish the MIPS Cost performance category weights for these performance years in future rulemaking

For the 2018 performance year, MIPS uses Cost measures that cover the total cost of care during the year and/or during a hospital stay.

CMS analyzes and evaluates Cost data by using individual NPIs and group TINs.

The two measures used to evaluate the Cost performance category for the 2018 performance year are:

Total Per Capita Costs for all Attributed Beneficiaries(TPCC)

and

Medicare Spending Per Beneficiary (MSPB)

TIP: CMS used earlier versions of these same measures for the Value Modifier (VM) program. A TPCC measure was used in the VM program beginning in 2015; all groups received feedback illustrating how they performed on this measure in the annual Quality and Resource Use Reports (QRURs). The MSPB measure was used in the VM program beginning in the 2016 payment adjustment period; feedback on this measure was provided in annual QRURs starting in 2014.

CMS uses Medicare claims data to calculate cost measure performance, which means clinicians **do not have to submit any data for this performance category.**

COST MEASURES

Overview of the TPCC and MSPB Measures

There are certain features that apply to both the TPCC and MSPB measures. These include:

Payment Standardization

The payments included in both the TPCC and MSPB measures are payment-standardized (sometimes referred to as "price standardized") to preserve differences that result from health care delivery choices, exclude geographic differences, and exclude payment adjustments from special Medicare programs. Payment standardization assigns a comparable amount for the same service provided in different settings to reveal differences in spending that results only from care decisions and resources use. (More details are included in this CMS Price (Payment) Standardization- Detailed Methods document.)

The allowed amounts for Medicare services can vary across geographic areas due to several factors, such as:

- Regional differences in labor costs and practice expenses
- Differences in relative price of inputs in local markets where a service is provided
- Extra payments from Medicare in medically underserved regions
- Policy-related adjustments due to performance in quality programs

Benchmarks

CMS will establish a single, national benchmark for each cost measure. These benchmarks are based on the performance period, not a historical baseline period. Therefore, CMS can't publish the actual numerical benchmarks for the cost measures before the start of each performance period. All MIPS eligible clinicians that meet or exceed the case minimum for a measure are included in the same benchmark.

For Example: The MSPB benchmark used to determine MIPS eligible clinicians' 2018 Cost performance category score will be based on CY 2018 data.

Attribution

CMS attributes beneficiaries and their costs to clinicians. In the VM Program, Cost measures were attributed to a TIN (associated with either a group practice or a solo practitioner). Under MIPS, CMS will attribute cost measures at the TIN-NPI level. Although Cost measures will be attributed to individual clinicians, cost measure performance can be assessed by CMS at either the individual clinician level, group level, or virtual group level.

If you're participating in MIPS as a group or virtual group and submitted data as a group for other MIPS performance categories, your Cost performance category score will be determined by aggregating the scores of the individual clinicians within the TIN. However, the method used to attribute beneficiary costs to MIPS eligible clinicians at the TIN-NPI level differs between the two measures.

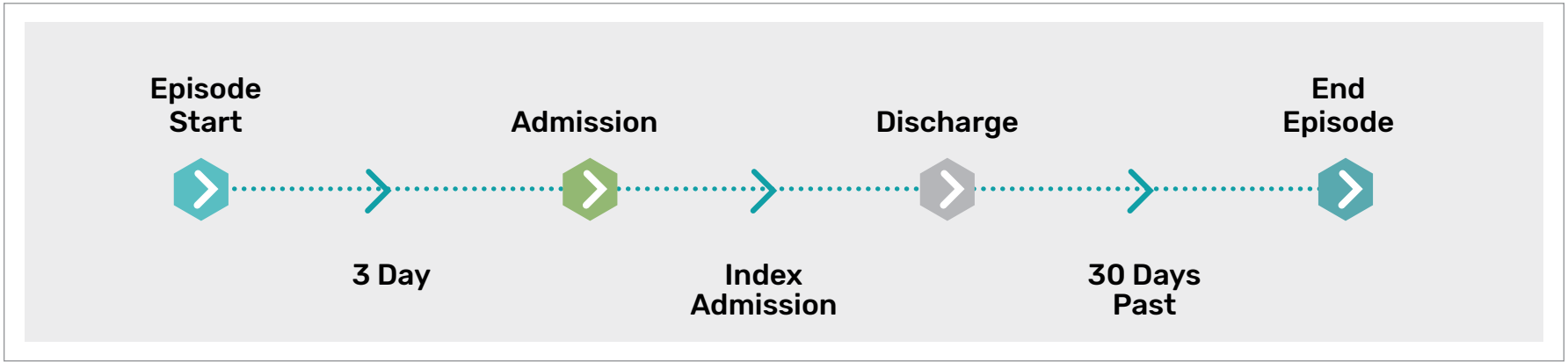
[2]Medicare allowed amounts include the amount of the Medicare Trust Fund payment plus any applicable beneficiary deductible and coinsurance amounts. In some cases, beneficiary deductibles and coinsurance amounts may be covered by third party payers other than Medicare.

Medicare Spending Per Beneficiary (MSPB) Overview

The MSPB measure assesses total Medicare Part A and Part B costs incurred by a beneficiary during an "episode," and compares these observed costs to expected costs.

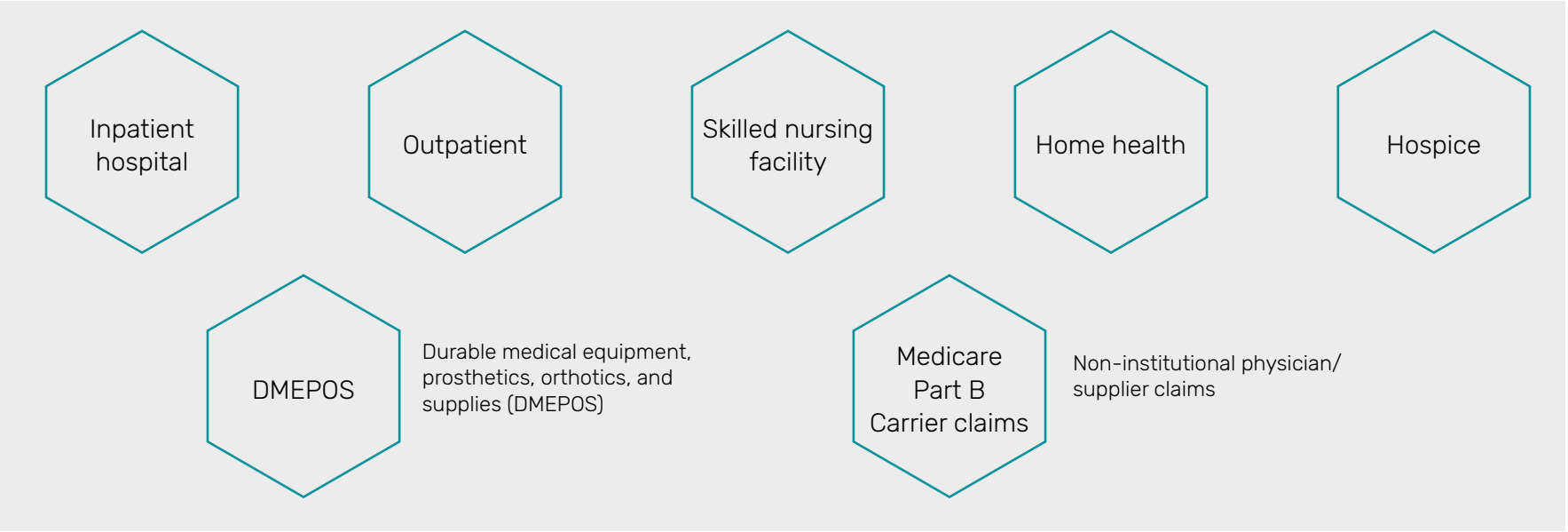
Expected costs are based on the clinical condition or procedure that triggers the episode along with other factors that may influence cost, but are not directly related to patient care.

- An episode includes all Medicare Part A and B claims with start dates within the episode window—the period of time beginning **3 days before an index admission through 30 days** after hospital discharge.
- An index admission is the admission with a principal diagnosis of a specified condition that meets the inclusion and exclusion criteria for the measure.



MSPB Overview *(continued)*

All Medicare Parts A and B claims for items and services provided during the episode window are included in an MSPB episode, including the following claim types:



MSPB Attribution

- CMS "attributes" each MSPB episode to a MIPS eligible clinician (identified by a single TIN-NPI) who provided the most Part B physician/supplier services—measured by the dollar amount of Medicare-allowed charges—during the period between the index admission date and the discharge date.
- In the case of a tie, an episode will be attributed to the clinician with the most Part B services bill lines. If multiple clinicians have the same count of service bill lines, the episode is then randomly attributed.
- As noted above, CMS attributes MSPB episodes at the individual clinician level via a clinician's unique TIN-NPI. However, for groups of clinicians who are participating in MIPS as a group, a single measure score will be calculated for and assigned to the group, based on combined data.

To determine the clinician who provided the most Part B physician/supplier services, CMS considers the following Part B services billed by MIPS eligible clinicians:

- Part B services provided on the admission date and in a hospital setting with place of service (POS) restricted to hospital inpatient, outpatient, or emergency room
- Part B services provided during the index hospital stay, regardless of POS
- Part B services provided on the discharge date with a POS restricted to inpatient hospital

MSPB Attribution

Beneficiaries are excluded from the MSPB measure (and their hospital stay costs are not attributed to a clinician) for any one of the following reasons:

- The beneficiary was not continuously enrolled in both Medicare Parts A and B during the **93-day period prior to the index admission through 30 days after discharge**
- The beneficiary died during the episode
- The beneficiary was enrolled in Medicare Advantage (MA) or Medicare was the beneficiary's secondary payer at any time during the episode window or the 90-day look-back period. If Medicaid was the beneficiary's primary payer during an episode because of exhaustion of Part A benefits, these episodes are not excluded and are attributed to a TIN-NPI

> This time frame includes an additional 90-day period (referred to as the "90-day look-back period") because this period is used to identify a beneficiary's comorbidities for use in risk-adjustment

The beneficiary was discharged for the index admission in the last 30 days of the performance period

Beneficiaries are also excluded if **their index admission**:

- Did not occur in a "subsection (d) hospital[3]" paid under the Inpatient Prospective Payment System (IPPS) or an acute hospital in Maryland
- For the episode was involved in an acute-to-acute hospital transfer[4]
- Occurred within the 30-day post discharge period of another MSPB episode for the same beneficiary[5]

[1]Subsection (d) hospitals do not include: psychiatric hospitals, rehabilitation hospitals, children's hospitals, long-term care hospitals, and hospitals involved extensively in the treatment for or research on cancer.

[2]If an acute-to-acute hospital transfer and/or hospitalization in an IPPS-exempt hospital occurs during the 30 days following discharge from an index admission, then these post-discharge costs are included in the MSPB episode.

[3]In this case, the second hospital admission is considered a readmission and its costs are still included in the initial MSPB episode; the readmission does not trigger a new MSPB episode.

MSPB Case Minimum

The minimum case volume for the MSPB measure is 35, meaning 35 MSPB episodes must be attributed to a MIPS eligible clinician or group for the measure to be scored. For groups, a total of 35 MSPB episodes must be attributed across all clinicians (including MIPS eligible clinicians AND eligible clinicians) who have re-assigned their billing rights to the group's TIN.

A clinician who is participating in MIPS as an individual will not receive a MSPB measure score if the clinician does not bill Medicare for Part B physician/supplier services furnished to beneficiaries during hospital stays.

MSPB Risk Adjustment

The MSPB measure is risk adjusted to account for beneficiary age and illness severity. A beneficiary's illness severity is determined by using the following indicators:

- 79 Hierarchical Condition Category (HCC) indicators[6] from a beneficiary's claims during the 90-day period before the start of the episode
- Recent long-term care status
- End stage renal disease (ESRD) status
- The Medicare Severity Diagnosis-Related Group (MS-DRG) code of the index hospital admission[7]

The MSPB risk adjustment method accounts for:

- Comorbidities (the presence of more than one simultaneous clinical condition) by including interactions between HCC variables and enrollment status variables
- The reason a beneficiary qualified for Medicare—referred to as a beneficiary's entitlement category
- Disease interactions that are included in the Medicare Advantage risk adjustment model
- **Note:** The MSPB measure is not adjusted to account for beneficiary sex, race, or provider specialty. It's adjusted based on the index admission diagnosis-related group.

The goal of **risk adjustment** is to enable more accurate comparisons across clinicians and groups who treat beneficiaries of varying clinical complexity. Risk adjustment removes differences in illness severity and controls for other risk factors that may affect measured outcomes but are outside of a clinician or group's control.

[6]The 79 HCC indicators are in Version 22 of the CMS-HCC model

[7]In the MSPB risk adjustment methodology, a separate risk adjustment model is used to calculate the risk-adjusted, expected MSPB episode cost for each major diagnostic category (MDC). MDCs are determined by the MS-DRG of the index hospital admission.

MSPB Calculation

CMS uses the following six steps to calculate the MSPB measure:

Step 1: Define the population of index admissions.

Step 2: Calculate payment-standardized MSPB episode spending.

Step 3: Calculate the expected, risk-adjusted MSPB episode spending.

TIP: For more detailed information, see the 2018 MIPS MSPB Measure Information Form.

Expected episode spending represents the relationship between independent variables (e.g., age, enrollment status, comorbidities, HCCs) and the standardized episode cost. It's calculated using a model based on beneficiary age and severity of illness, as described in the risk adjustment methodology section of the measure information form. The risk-adjusted measure reflects a TIN-NPI's average ratio of observed to expected episode spending across all episodes attributed to the TIN-NPI.

Step 4: Exclude outliers.

Step 5: Attribute episodes to individual clinicians.

Step 6: Calculate and report the MSPB measure for each TIN-NPI or TIN.

Individuals = (Sum of Ratios* X National Average) / Total # of MSPB Episodes**

*The sum of the ratios of payment-standardized observed to expected MSPB episode costs for all MSPB episodes attributed to an individual clinician's TIN-NPI

**Total number of MSPB episodes attributed to an individual MIPS eligible clinician's TIN-NPI

Groups = (Sum of Ratios* X National Average) / Total # of MSPB Episodes**

*Sum of the ratios of payment-standardized observed to expected MSPB episode costs for all MSPB episodes attributed to all individual eligible clinicians' TIN-NPIs under the group's TIN

**Total number of MSPB episodes attributed to all individual eligible clinicians' TIN-NPIs under the group's TIN

Total Per Capita Cost **for all Attributed Beneficiaries** (TPCC)

The TPCC measure assesses total Medicare Parts A & B costs for a beneficiary during the performance period by calculating the risk-adjusted, per capita costs for beneficiaries attributed to an individual clinician or group of clinicians.

Sum of Costs	**Numerator** = Sum of the annualized, risk adjusted, specialty-adjusted Medicare Parts A & B costs incurred by all beneficiaries attributed to an individual MIPS eligible clinician (TIN-NPI) or all individual eligible clinicians in a group (identified by TIN) that is participating in MIPS as a group
# of beneficiaries in a MIPS TIN or TIN-NPI	**Denominator** = Number of Medicare beneficiaries who are attributed to an individual MIPS eligible clinician's TIN-NPI (if participating in MIPS as an individual) or the number of all Medicare beneficiaries who are attributed to a group of individual eligible clinicians participating in MIPS as a group (TIN) during the performance period

The TPCC measure is calculated through the following steps:

1. Attribute beneficiaries to TIN-NPIs
2. Calculate payment-standardized per capita costs
3. Annualize costs for partial year-enrolled Medicare beneficiaries included in the measure
4. Risk-adjust costs
5. Specialty-adjust costs
6. Calculate the TPCC measure for the TIN-NPI or TIN
7. Report/express the TPCC measure for the TIN-NPI or TIN

TPCC Attribution

Beneficiaries are attributed to a single TIN-NPI based on the amount of primary care services a beneficiary received, and the clinician specialties that performed those services, during the performance period.

Only beneficiaries who received a primary care service during the performance period can be attributed to a TIN-NPI. A beneficiary is attributed to a single TIN-NPI or to a single entity's CMS Certification Number (CCN) assigned to either a Federally-Qualified Health Center (FQHC) or Rural Health Clinic (RHC) in one of two steps, which are outlined on the next page.

Primary care services include:

- Evaluation and management services furnished in office and other non-inpatient, non-emergency room settings
- Initial Medicare visits
- Annual wellness visits

Note: If a beneficiary is attributed to an FQHC or RHC's CCN, then that beneficiary and the beneficiary's costs are not included in the TPCC measure calculated for an individual MIPS eligible clinician or group and the beneficiary is excluded from risk adjustment.

TPCC Attribution

Two-step attribution process:

1 **If a beneficiary received more primary care services from an individual TIN-NPI that is classified as either a primary care physician (PCP), nurse practitioner (NP), physician assistant (PA) or clinical nurse specialist (CNS) than from any other TIN-NPI during the performance period, then the beneficiary is attributed to that TIN-NPI. If, during the performance period, a beneficiary received more primary care services from an entity's CCN than from any other TIN-NPI, then the beneficiary is attributed to the CCN.**

2 **If a beneficiary did not receive a primary care service from a TIN-NPI classified as either a PCP, NP, PA, or CNS during the performance period, then the beneficiary may be assigned to a TIN-NPI in "Step 2." If a beneficiary received more primary care services from a specialist physician's TIN-NPI than from any other provider's TIN-NPI during the performance period, then the beneficiary is assigned to the specialist physician's TIN-NPI.**

TIP: For a list of medical specialties included in Step 2, please refer to Table 4 of the 2018 MIPS TPCC Measure Information Form. For a list of Healthcare Common Procedure Coding System (HCPCS) codes that identify primary care services, please refer to Table 2 of the same document.

Did the beneficiary receive any primary care services from a **PCP, NP, PA, and/or CNS?**

No

Yes → Beneficiary is attributed to the TIN-NPI of the **PCP/NP/PA/CNS** that provided more allowed charges for primary care services than any other TIN-NPI

Did the beneficiary receive any primary care services from a **specialist physician?**

No

Yes → Beneficiary is attributed to the TIN-NPI of the **specialist physician** that provided more allowed charges for primary care services than any other TIN-NPI

Beneficiary not attributed to any TIN-NPI.

TPCC Attribution

A beneficiary is excluded from the population measured if the beneficiary:

Was not enrolled in both Medicare Parts A & B for every month of the performance period

or

Was enrolled in a private Medicare health plan during any month of the performance period

or

Resides outside the United States (including territories) during any month of the performance period

If a beneficiary was enrolled in Medicare Parts A and B for a partial year because he/she newly-enrolled in Medicare or he/she died during the performance period, then the beneficiary is included in the measure.

TPCC Case Minimum

The case minimum for the TPCC measure is 20. To be scored on the TPCC measure:

MIPS eligible clinicians participating in MIPS as individuals must have at least 20 different beneficiaries attributed to their TIN-NPI

or

Groups participating in MIPS as a group must have a total of 20 beneficiaries attributed to TIN-NPIs across all of the TIN-NPIs under the group's TIN

MIPS eligible clinicians and groups with 19 or fewer beneficiaries attributed to them won't be scored on the TPCC measure.

If You Don't Meet the Case Minimum for Either of the Two Cost Measures:

- Your Cost performance category will be weighted at 0% of your MIPS Final Score
- The weight of your Quality performance category score will increase from 50% to 60% of your MIPS Final Score

TPCC Risk Adjustment Methodology

Two measures of risk are used in the TPCC risk adjustment methodology:

CMS-HCC Model

Beneficiaries' CMS-HCC risk scores derived from the CMS-HCC model for continuing beneficiaries or from the community

and

ESRD

ESRD status

Separate CMS-HCC models exist for new enrollees and continuing enrollees. The new enrollee model accounts for a beneficiary's age, sex, disability status, original reason for Medicare entitlement (age or disability), and Medicaid eligibility, and is used when a beneficiary has less than 12 months of medical history. The community model is used when a beneficiary has at least 12 months of medical history. The community model includes the same demographic information as the new enrollee model but it also accounts for clinical conditions as measured by Hierarchical Condition Categories (HCCs).

Specialty adjustment

Specialty adjustment is also applied to the TPCC measure. Specialty adjustment differs from risk adjustment because it is performed at the provider level rather than the beneficiary level.

CMS adjusts the TPCC measure based on the specialty of the individual MIPS eligible clinician (for those participating in MIPS as an individual) or the specialty composition of a group of clinicians participating in MIPS as a group under a specific TIN. An individual clinician's specialty is identified based on the CMS specialty code listed most frequently on Medicare Part B claims for services provided by the clinician during the performance year.

TIP: For information on how specialty adjustment was implemented in the 2018 VM Program, please refer this 2018 VM Program fact sheet.

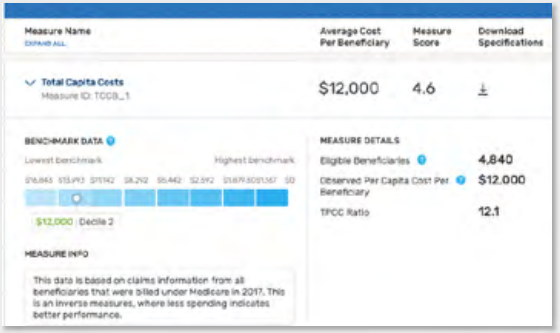
REPORTING REQUIREMENTS

CMS will use data from Medicare Part A and B claims—with dates of service from January 1, 2018 to December 31, 2018—to calculate your Cost performance category score.

- You **do not** need to submit any data or take any separate actions for this performance category.
- MIPS eligible clinicians should continue to see patients and submit claims as usual.

SCORING

For a cost measure to be scored, an individual MIPS eligible clinician or group must have enough attributed cases to meet or exceed the case minimum for that cost measure.



- If **only one** Cost measure can be scored, that measure's score will serve as the Cost performance category score
- If **both** Cost measures are scored, the Cost performance category score is the equally-weighted average of the scored measures
- If **neither** measure can be scored, the Cost performance category will count toward 0% of your MIPS final score, and we'll reweight your Quality performance category score to 60%

20 MSPB episodes + **20** TPCC beneficiaries

For example:
You have 20 MSPB episodes attributed to you for the MSPB measure and 20 beneficiaries attributed to you for the TPCC measure.

Which, if any, cost measures would your Cost performance category score include?

Your Cost performance category score would only include the TPCC measure because:

- You're below the 35-case minimum required in order to be scored on MSPB
- You meet the 20-case minimum necessary to be scored on TPCC

The following figures show examples of different Cost performance category scoring scenarios. These are just EXAMPLES for illustrative purposes only.

Reporting Level: Group/Virtual Group			
Condition:	**Scenario 1**	**Scenario 2**	**Scenario 3**
# of MSPB episodes attributed across all individual clinicians (identified by TIN-NPI) who assigned their billing rights to the TIN of the group participating in MIPS as a group	**54**	**245**	**14**
MSPB measure scored for the group?	**Yes**	**Yes**	**No**
# of TPCC beneficiaries attributed across all individual clinicians (identified by TIN-NPI) in the group (identified by TIN) who have assigned their billing rights to the group's TIN, based on primary care services received by the beneficiaries during the performance period	**18**	**23**	**6**
TPCC measure scored for the group?	No—the group did not meet the minimum case volume for the measure	**Yes**	**No**
# of cost measures scored	**1**	**2**	**0**
# of total possible cost achievement points available based on the # of cost measures scored	**10**	**20**	**0**

Reporting Level: Group, *continued*			
Condition:	**Scenario 1**	**Scenario 2**	**Scenario 3**
Points assigned to the MSPB measure, based on performance compared to single, national benchmark	**6.5**	**6.4**	**N/A- not scored**
Points assigned to the TPCC measure (based on performance compared to single, national benchmark)	**N/A- not scored**	**9.1**	**N/A- not scored**
Cost performance category weight	**10%**	**10%**	0%- the Quality performance category is reweighted to 60% of the group's 2018 MIPS total score
Cost performance category percent score	6.5/10= 0.65 x 100= 65%	6.4+9.1=15.5 / 20=0.775 x 100= 77.5% Mathematically equivalent to [(6.4/10) + (9.1/10)] / 2 = 0.775 X 100= 77.5%	**N/A**

Reporting Level: Individual			
Condition:	**Scenario 1**	**Scenario 2**	**Scenario 3**
# of MSPB episodes attributed to the individual clinician's TIN-NPI	**34**	**60**	**36**
MSPB measure scored for the individual?	**No**	**Yes**	**No**

Reporting Level: Individual, *continued*			
Condition:	**Scenario 1**	**Scenario 2**	**Scenario 3**
# of TPCC beneficiaries attributed to the individual clinician's TIN-NPI based on primary care services received by beneficiaries during the performance period	**29**	**90**	**11**
TPCC measure scored for the individual?	**Yes**	**Yes**	**No**
# of Cost measures scored	**1**	**2**	**0**
# of total possible Cost achievement points available based on the # of Cost measures scored	**10**	**20**	**0**
Points assigned to the MSPB measure, based on performance compared to single, national benchmark	**N/A- not scored**	**4.4**	**N/A- not scored**
Points assigned to the TPCC measure (based on performance compared to single, national benchmark)	**3.6**	**4.8**	**N/A- not scored**
Cost performance category weight	**10%**	**10%**	0%- the Quality performance category is reweighted to 60% of the individual MIPS eligible clinician's 2018 MIPS Final Score
Cost performance category percent score	**36%** (3.6/10)X100=36%	**46%** [(4.4/10)+(4.8/10)/2]= 0.46X100=46%	**N/A**

CMS will assign 1 to 10 achievement points to each scored measure based on the MIPS eligible clinician or group's performance on the measure compared to the performance period benchmark.

Cost Performance Category Scoring Scenario		
Measure	**Measure achievement points earned by the group**	**Total possible measure achievement points**
TPCC measure	**8.2**	**10**
MSPB measure	**6.4**	**10**
TOTAL	**14.6**	**20**

In this scenario, a clinician group meets the case minimums for both cost measures. In 2018, the group earns 8.2 points for TPCC, and 6.4 points for MSPB.

CMS sums the two scores

8.2 TPCC measure + **6.4** MSPB measure = **14.6** ÷ **2** = **7.3** Total Points to Final Score

Divided by

(Looked at another way, the group earned 14.6—or 73%—of 20 possible points.)
With the Cost performance category worth 10%, the group has earned 7.3 points toward its MIPS final score

If the same clinician group met the case minimum for TPCC but not for MSPB:

- The group's Cost performance category score would be 8.2 out of 10 total points available
- The group would earn 8.2 points toward its MIPS final score

COST PERFORMANCE CATEGORY FEEDBACK

Cost Performance Category Feedback

In July 2018, CMS provided feedback on TPCC and MSPB cost measure performance to MIPS eligible clinicians and groups even though the Cost performance category did not count towards 2017 MIPS Final Scores nor will it affect 2019 payments.

Note: Beneficiary-level data is not available for 2017 cost measure performance reflected in 2017 MIPS Performance Feedback Reports and CMS is unable to provide it.

Feedback on 2018 MIPS performance period cost measure performance will be available in summer 2019 and CMS is looking to incorporate beneficiary-level data, if technically feasible.

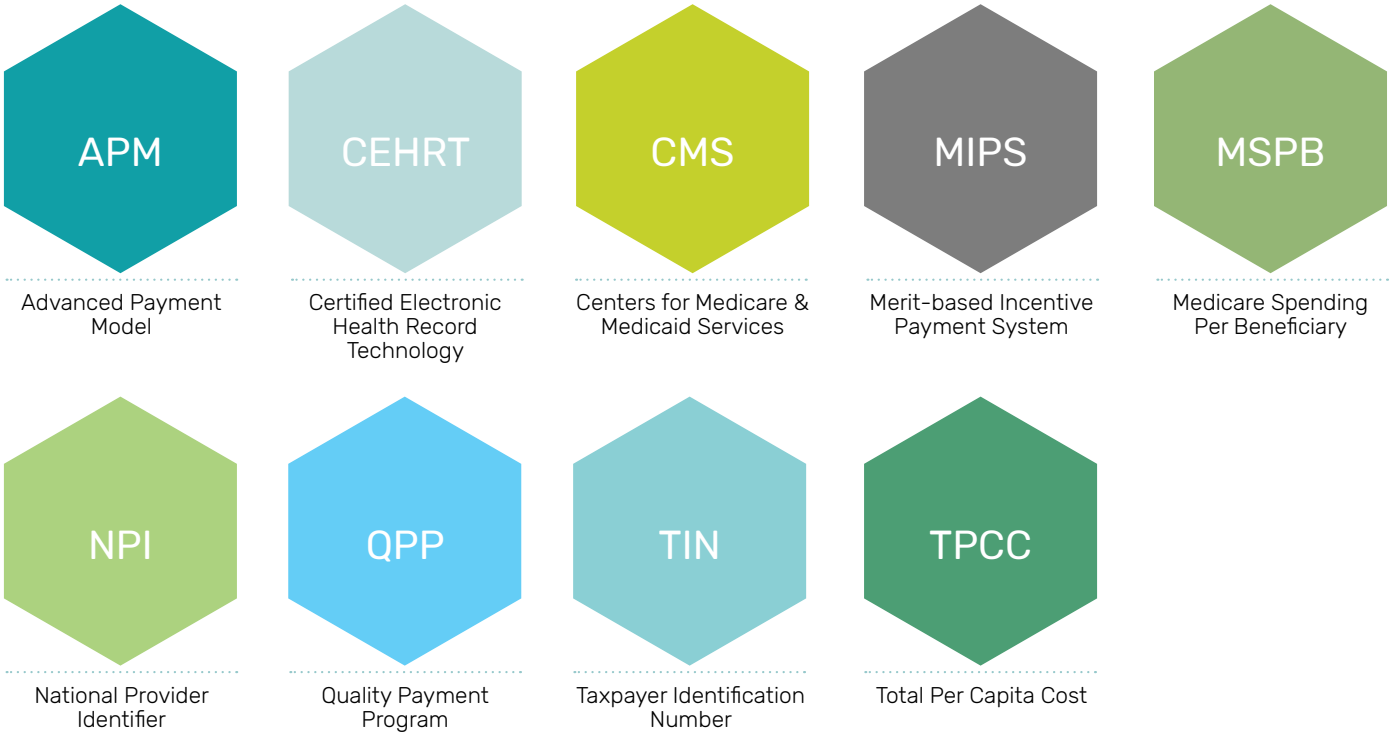
RESOURCES AND GLOSSARY

Resources

You can find more resources at these links:

- 2018 Cost Measures
- 2018 Cost Performance Category Fact Sheet
- 2018 Cost Requirements
- MIPS Participation and Overview Fact Sheet
- MIPS Year 2 Scoring 101 Guide

Glossary


APM
Advanced Payment Model
CEHRT
Certified Electronic Health Record Technology
CMS
Centers for Medicare & Medicaid Services
MIPS
Merit-based Incentive Payment System
MSPB
Medicare Spending Per Beneficiary
NPI
National Provider Identifier
QPP
Quality Payment Program
TIN
Taxpayer Identification Number
TPCC
Total Per Capita Cost