Quality Payment
PROGRAM

2018 COST PERFORMANCE CATEGORY WEBINAR

Disclaimers

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

Topics

- Merit-based Incentive Payment System (MIPS) Year 2 Basics
- Overview of the Cost Performance Category
- Scoring the Cost Performance Category
- How to Prepare for Cost in 2018
- Technical Assistance Resources

Quality Payment Program

MIPS and Advanced APMs

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides for two participation tracks:

MIPS

The Merit-based Incentive Payment System (MIPS)

If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

<u>*OR*</u>

Advanced APMs

Advanced Alternative Payment Models (Advanced APMs)

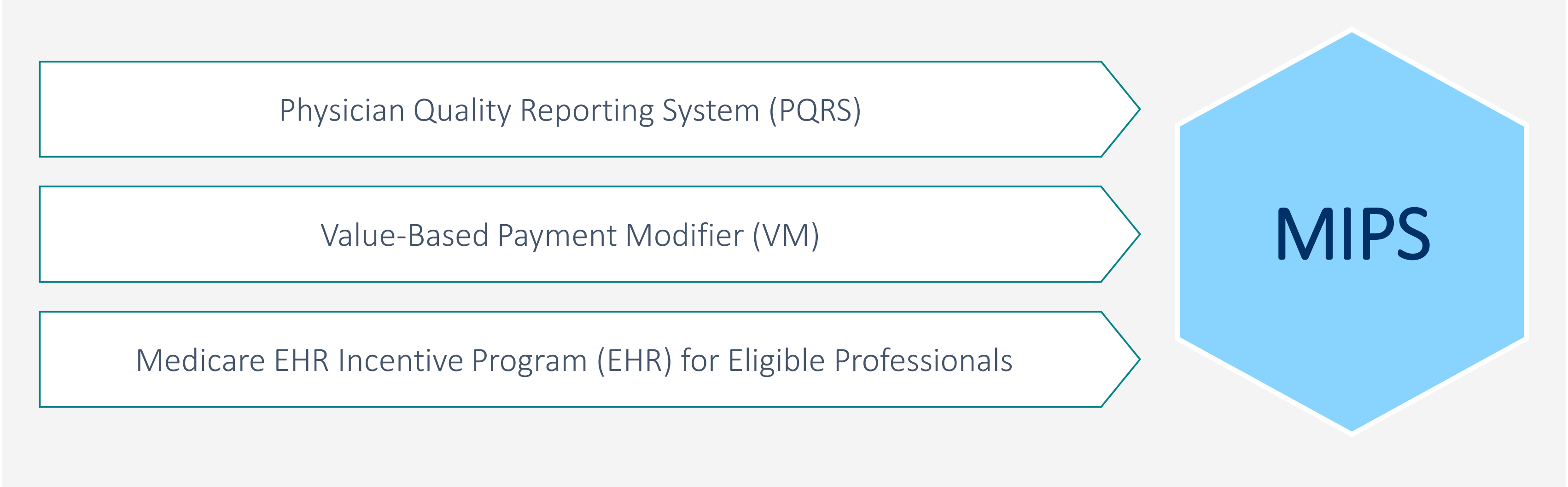
If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Merit-based Incentive Payment System (MIPS)

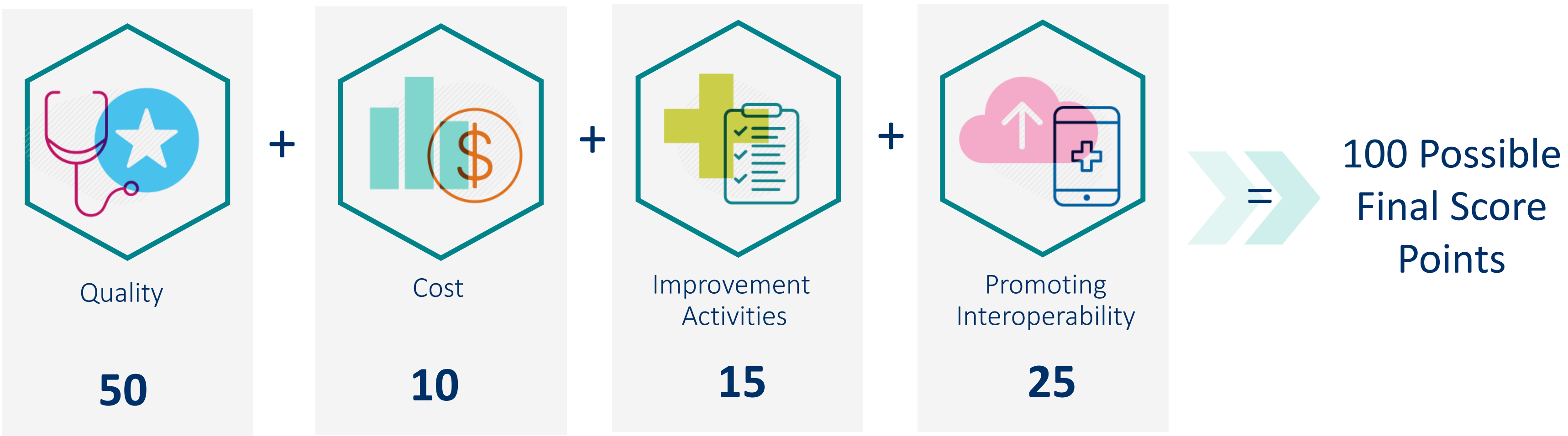
Quick Overview

Combined legacy programs into a single, improved program.



Merit-based Incentive Payment System (MIPS)

Quick Overview



- Comprised of **four** performance categories in 2018.
- **So what?** *The points from each performance category are added together to give you a MIPS Final Score.*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

Merit-based Incentive Payment System (MIPS)

Changing Advancing Care Information to Promoting Interoperability

- On April 24, 2018, CMS released the Medicare Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) proposed rule.

- This rule established a new name for the MIPS Advancing Care Information performance category – the **Promoting Interoperability** performance category.

- **Please note:** Promoting Interoperability is **not** a new performance category; it's just the new name for the Advancing Care Information performance category. This new name better reflects our increased focus on interoperability and improving patient access to health information.

- **The 2018 requirements for the Promoting Interoperability performance category are exactly the same as what was finalized for the Advancing Care Information performance category.**

MIPS YEAR 2 (2018)

Participation Basics

MIPS Year 2 (2018)

Who is Included?

No change in the types of clinicians eligible to participate in 2018.

MIPS eligible clinicians include:

Physicians

Physician Assistants

Nurse Practitioners

Clinical Nurse Specialists

Certified Registered Nurse Anesthetists

MIPS Year 2 (2018)

Who is Included?

Change to the Low-Volume Threshold for 2018. Includes MIPS eligible clinicians billing more than $90,000 a year in allowed charges for covered professional services under the Medicare PFS **AND** furnishing covered professional services to more than 200 Medicare beneficiaries a year.

Voluntary reporting remains an option for those clinicians who are exempt from MIPS.

MIPS Year 2 (2018)

Who is Exempt?

No change in basic exemption criteria.*

Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

Below the Low-Volume Threshold

- Allowed charges for covered professional services under the Medicare PFS less than or equal to **$90,000** a year

OR

- Furnish services to **200** or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs

- Receive 25% of their Medicare payments

OR

- See 20% of their Medicare patients through an Advanced APM

**Only Change to Low-Volume Threshold*

MIPS Year 2 (2018)

Performance Period

Change: Increase to Performance Period

Transition Year 1 (2017) Final

Performance Category	Minimum Performance Period
Quality	90-days minimum; full year (12 months) was an option
Cost	Not included. 12-months for feedback only.
Improvement Activities	90-days
Promoting Interoperability	90-days

Year 2 (2018) Final

Performance Category	Minimum Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Promoting Interoperability	90-days

MIPS Year 2 (2018)

Timeline for Year 2

2018
Performance Year

- Performance period opens January 1, 2018.
- Closes December 31, 2018.
- Clinicians care for patients and record data during the year.

March 31, 2019
Data Submission

- Deadline for submitting data is March 31, 2019.
- Clinicians are encouraged to submit data early.

Feedback

- CMS provides performance feedback after the data is submitted.
- Clinicians will receive feedback before the start of the payment year.

January 1, 2020
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2020.

COST PERFORMANCE CATEGORY IN 2018

Cost Performance Category

In 2017, we didn't score the Cost category, so:

- The maximum score was 0
- Cost performance accounted for 0% of your Final Score

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

- Has a maximum score of 10
- Accounts for 10% of your Final Score*

*For MIPS APMs, Cost continues to account for 0% of your Final Score. CMS hasn't changed the MIPS APM scoring standard for Cost for the 2018 performance year.

Why Focus on Cost?

Our goal is to align Cost measures with quality of care assessment so that we can work toward:

- Better patient outcomes
- Smarter spending

2018 Cost Measures

Overview

- CMS analyzes and evaluates Cost data by using individual National Provider Identifiers (NPIs) and group Taxpayer Identification Numbers (TINs).
  - Individual clinicians are identified by a unique TIN-NPI.
- The two Cost measures for the 2018 performance year are:
  - Medicare Spending Per Beneficiary (MSPB)
  - Total Per Capita Cost (TPCC)

- ***Tip:*** We used earlier versions of these same measures for the Physician Value Modifier program. If you participated in that legacy program, you'll be familiar with these measures.

2018 Cost Measures

Medicare Spending Per Beneficiary Measure

- CMS uses MSPB to assess the cost of Part A and Part B claims during an "episode" – the period immediately before, during, and after a patient's hospital stay.
- An IPPS (or Inpatient Prospective Payment System) hospital admission triggers an "episode."
- These IPPS hospital admissions are called "index admissions."
- An MSPB episode spans the dates from 3 days before an index admission to 30 days after hospital discharge.

MSPB: Attribution

- For MSPB we “attribute” each episode to the clinician who provided the most Part B/Physician Supplier (Part B) services—in terms of the dollar amount of Medicare-allowed charges—during the index admission.
- In the case of a tie, an episode will be attributed to the clinician who has the highest count of Part B services.
- We attribute episodes at the individual clinician level via the clinician’s TIN/ NPI. However, those who participate as groups will have a single score for their group, based on the combined data.

2018 Cost Measures

MSPB Measure

MSPB: Case Minimum

- You must have at least 35 episodes attributed to you to be scored on MSPB.
- You **won't** be scored on MSPB if:
  - You have 34 or fewer episodes attributed to you
  - You did not bill Part B services in hospital stays during the performance period.

2018 Cost Measures

Total Per Capita Cost (TPCC) Measure

- CMS uses the Total Per Capita Cost (TPCC) measure to measure all of Medicare Part A and Part B costs during the MIPS performance period.

- For the TPCC measure, beneficiaries are assigned to a single Medicare clinician TIN-NPI in a two step process that considers:
  - The level of primary care services they received (as measured by Medicare allowed charges during the performance period) and,
  - The clinician specialties that performed these services.

2018 Cost Measures

TPCC Measure

Total Per Capita Cost (TPCC): Attribution

- TPCC assesses all Part A and B claims.
- For this measure, attribution is a 2-step process:
    1. Attribute a beneficiary to the TIN-NPI who provided the most primary care services based on allowed charge amount from primary care physicians, nurse practitioners, physician assistants or clinical nurse specialists
    2. If a beneficiary is not attributed in Step 1, attribute a beneficiary to the TIN-NPI who provided the most primary care services based on allowed charge amount from non-primary care specialist

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

2018 Cost Measures

TPCC Measure

TPCC: Attribution

- Beneficiaries who receive no primary care services aren’t attributed.
- In the case of a tie, an episode will be attributed to the clinician who most recently provided services in cases where two clinicians are tied.

2018 Cost Measures

TPCC Measure

TPCC: Case Minimum

- To be scored on the TPCC measure, eligible clinicians and groups must have at least 20 different episodes attributed to them.
- Clinicians and groups with 19 or fewer episodes attributed to them won’t be scored on the TPCC measure.

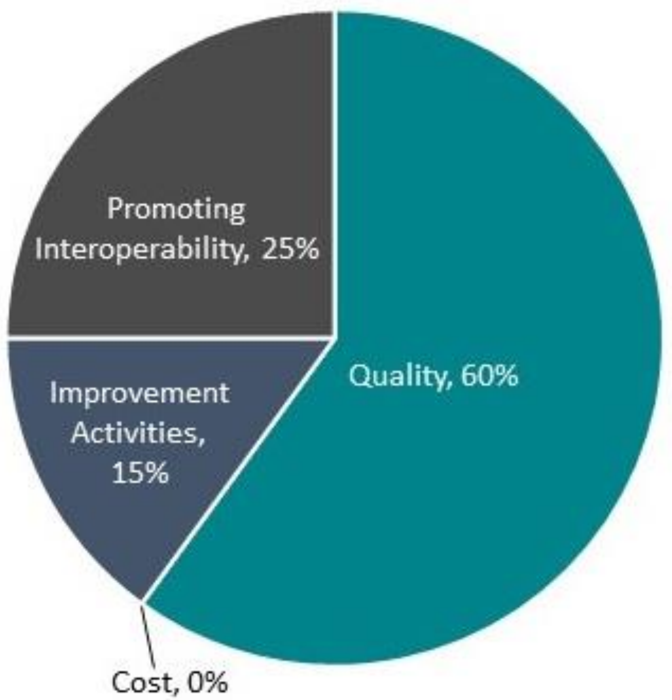
- ***Tip:*** Remember, you don’t need to submit any special data or reports for the Cost performance category. Just continue to see your patients and submit your Medicare Part A and B claims as usual.

2018 Cost Measures

MSPB and TPCC Measures

If You Don’t Meet Either Case Minimum

- If you don’t meet the case minimums to be scored on either Cost measure, your performance on Cost will count toward 0% of your MIPS Final Score.
- Instead the weight of your Quality score will increase from 50% to 60% of your MIPS Final Score.



Cost Measures Scenario

Scenario

- You have 20 episodes attributed to you for the MSPB measure and 20 episodes attributed to you under the TPCC.

Which, if any, Cost measures would your score include?

Your score would only include TPCC because:

- You're below the 35 case minimum for being scored on MSPB.
- You're at the 20 case minimum for being scored on TPCC.

Episode-based Measures

- For the 2018 performance year, we've discontinued episode-based measures from the CY 2017 Quality Payment Program final rule.
- To develop improved episode-based measures for future years, CMS is taking a collaborative approach that includes front-line clinicians.
- We expect to propose new Cost measures in future rulemaking and to solicit feedback on new episode-based measures before including them in MIPS.

What are episode-based measures?

- An episode-based measure focuses only on services related to the clinical condition or procedure being measured.
- This is different from the MSPB and TPCC measures that include payments for all Part A and Part B services provided to a patient over a specific time period.

COST PERFORMANCE CATEGORY SCORING

Cost Performance Category Scoring

To figure your Cost score, CMS will:

- **Compare your performance** to other MIPS-eligible clinicians and groups *during the 2018 performance year.*
- **Assign 1 to 10 achievement points** to each measure based on your performance. Measures are risk-adjusted to account for differences in beneficiary-level risk that can affect medical costs, no matter the quality of care provided.
- **Average your achievement points** on the two measures.

Cost Performance Category Scoring

Example

Scenario

Measure	Measure Achievement Points	Total Possible Achievement Points
TPCC Measure	8.2	10
MSPB Measure	6.4	10
Total	**14.6**	**20**

- 14.6 of 20 possible points = 73%
- 7.3 points toward MIPS Final Score

What Data Does CMS Use for Cost Scores?

- CMS will use data from Medicare Part A and B claims with dates of service from Jan 1 to Dec 31, 2018.
- You don’t need to take any separate actions or submit anything special to report on MIPS.

- *Tip:* Just continue to see your patients and submit your Medicare Part A and B claims as usual.

PREPARING FOR COST IN 2018

Preparing for Cost 2018

Dr. Dale Bratzler – Clinician Champion Program

- Professor in the Colleges of Medicine and Public Health
- Has served for the past six years as the Chief Quality Officer for OU Physicians, the faculty practice of the OU College of Medicine
- Responsible for PQRS, Meaningful Use, Transforming Clinical Practice Initiative (TCPI) and more recently, MIPS and our CPC+ implementation
- In July became the Enterprise Chief Quality Officer for the entire OU Medicine campus.
- Honored to serve as a Quality Payment Program Clinical Champion since 2016

Preparing for Cost in 2018

See Your Patients and Submit Your Claims as Usual

- Remember: We use Medicare claims data to analyze your Cost performance.
  - Those claims, however, include all Part A and Part B costs incurred by your patients
  - When I look at our data, the biggest drivers of cost include:
    - Hospitalization
    - ED Use
    - Readmissions
    - Use of post-acute care services

- *So what?* So you don't have to submit any additional data for the Cost category.

Preparing for Cost in 2018

Document Complex Cases

- Remember: We adjust scores for risk to account for differences in beneficiary-level risk that can affect quality outcomes or costs.
  - To enable more accurate comparisons across clinicians and groups that treat levels of varying clinical complexity, we adjust for health and other risk factors that affect outcomes but are beyond clinicians' control.
- *So what?* Be sure your ICD-10 coding and other documentation thoroughly detail clinical complexity of the diagnoses that you're treating.
  - Hierarchical Condition Categories (HCC) codes
  - Avoid, when feasible, "unspecified" or "uncomplicated" ICD-10 diagnosis codes if your medical record documentation supports the more complex codes

Preparing for Cost in 2018

Review Performance Feedback

- Even though Cost didn't count toward your total score in the 2017 performance year, we will provide you with feedback this year on your 2017 Cost performance if you met the attribution threshold for MSPB, TPCC, or both.
- Review the resources that CMS has provided:
  - 2017 Performance Feedback report – MIPS
  - Episode-Based Cost Measure Field Test Report
  - QRUR files
  - Alternate Payment Program reports
  - Bundled Payment reports

- *Tip:* You may have already been getting feedback from several years on Cost Measures from the Physician Feedback Program Quality and Resource Use Reports (QRURs). You can review those reports as well.

Preparing for Cost in 2018

Consult CMS Resources

CMS online resources for Quality Payment Program participants include:

- 2018 MIPS Cost Measures
- Quality Payment Program Resource Library

You can contact the CMS Quality Payment Program by:

- **Email** at QPP@cms.hhs.gov
- **Phone** at 1-866-288-8292 (TTY: 1-877-715-6222), Mondays – Fridays, 8 am – 8 pm ET

HELP AND SUPPORT

Technical Assistance

Available Resources

CMS has free resources and organizations on the ground to provide help to eligible clinicians included in the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

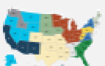
- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISCMail@us.ibm.com for extra assistance.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

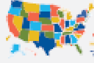
- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
  - For more information or for assistance getting connected, contact QPPSURS@IMPAQINT.COM.



LARGE PRACTICES

Quality Innovation Networks-
Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.



Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

To learn more, go to: https://qpp.cms.gov/about/help-and-support#technical-assistance

Help CMS Improve the Quality Payment Program

Interested in providing feedback to CMS as we continue to improve the Quality Payment Program experience?

We're looking for participants to collaborate with us to provide feedback on all aspects related to qpp.cms.gov, including:

- Products
- Services
- Educational Materials
- Website Content

These feedback sessions typically range from 30-60 minutes and can be done over the phone, via video conference, or through email. *

Email the QPP User Research Lead to participate in our feedback sessions!

*The user feedback sessions are not intended to replace the formal comment process that is open during the notice of Proposed Rulemaking (NPRM) period. Please submit all formal

Q&A SESSION

Q&A Session

To ask a question, please dial:

1-866-452-7887

If prompted, use passcode: **5778128**

Press ***1** to be added to the question queue.

You may also submit questions via the chat box.

Speakers will answer as many questions as time allows.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES