Quality Payment
PROGRAM

MACRA COST MEASURES FIELD TESTING WEBINAR

October 9, 2018
12:00 – 1:30 pm ET

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MACRA Cost Measures Field Testing Webinar

Agenda

- Introduction
- Episode-Based Cost Measures
  - Eleven procedural and acute inpatient medical condition measures
- Re-evaluated Cost Measures
  - Medicare Spending Per Beneficiary (MSPB) clinician
  - Total Per Capita Cost (TPCC)
- Field Testing
- Understanding the Field Test Reports
- Q&A Session

Acronyms Included in this Presentation

Acronym	Definition
APM	Alternative Payment Model
CMS	Centers for Medicare & Medicaid Services
DRG	Diagnosis Related Group
E&M	Evaluation and Management
MDC	Major Diagnostic Category
MIPS	Merit-based Incentive Payment System
MSPB	Medicare Spending Per Beneficiary
QPP	Quality Payment Program
QRUR	Quality and Resource Use Report
TEP	Technical Expert Panel
TIN	Tax Identification Number
TIN-NPI	Tax Identification Number/National Provider Identifier
TPCC	Total Per Capita Cost

INTRODUCTION

Background: The Quality Payment Program

- Clinicians can select how they want to participate in the program based on their practice size, specialty, location, or patient population
- Two tracks to choose from:

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.

or

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.

- MIPS composite performance score calculated for Eligible Clinicians using four categories:

Quality | Cost | Promoting Interoperability | Improvement Activities

MIPS Cost Performance Category

- **10 percent** of Final Score in MIPS 2018 performance period
- Measures in MIPS 2018 Cost Performance Category:
  - Medicare Spending Per Beneficiary
    - Plurality of Part B services billed during the index admission to determine attribution
    - Case minimum of 35
  - Total Per Capita Cost
    - Plurality of primary care services rendered by the clinician to determine attribution
    - Case minimum of 20
- No additional reporting requirement, clinicians assessed on Medicare claims data

Overview of Field Testing

- During field testing, we are gathering stakeholder feedback on:
  - Draft measure specifications for cost measures before consideration of their potential use in MIPS
  - Field test report templates
  - Supplemental documentation
- Feedback will be taken into consideration for potential measure refinement and future measure development activities
- Field testing is taking place from **October 3 to October 31, 2018**

Which Cost Measures are being Field Tested?

- Thirteen cost measures are being field tested before consideration of their potential use in MIPS
- **Eleven newly developed episode-based cost measures**
  - Acute Kidney Injury Requiring New Inpatient Dialysis
  - Elective Primary Hip Arthroplasty
  - Femoral or Inguinal Hernia Repair
  - Hemodialysis Access Creation
  - Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
  - Lower Gastrointestinal Hemorrhage
  - Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels
  - Lumpectomy, Partial Mastectomy, Simple Mastectomy
  - Non-Emergent Coronary Artery Bypass Graft (CABG)
  - Psychoses/Related Conditions
  - Renal or Ureteral Stone Surgical Treatment
- **Two re-evaluated cost measures***
  - Medicare Spending Per Beneficiary (MSPB) clinician[1]
  - Total Per Capita Cost (TPCC)

* The MSPB clinician and TPCC measures being field tested are separate from the measures used in the 2017 and 2018 MIPS performance periods. Field testing information about the re-evaluated MSPB clinician and TPCC measures does not affect your MIPS score or payment adjustments.

EPISODE-BASED COST MEASURES

- 11 Procedural and Acute Inpatient Medical Condition Measures

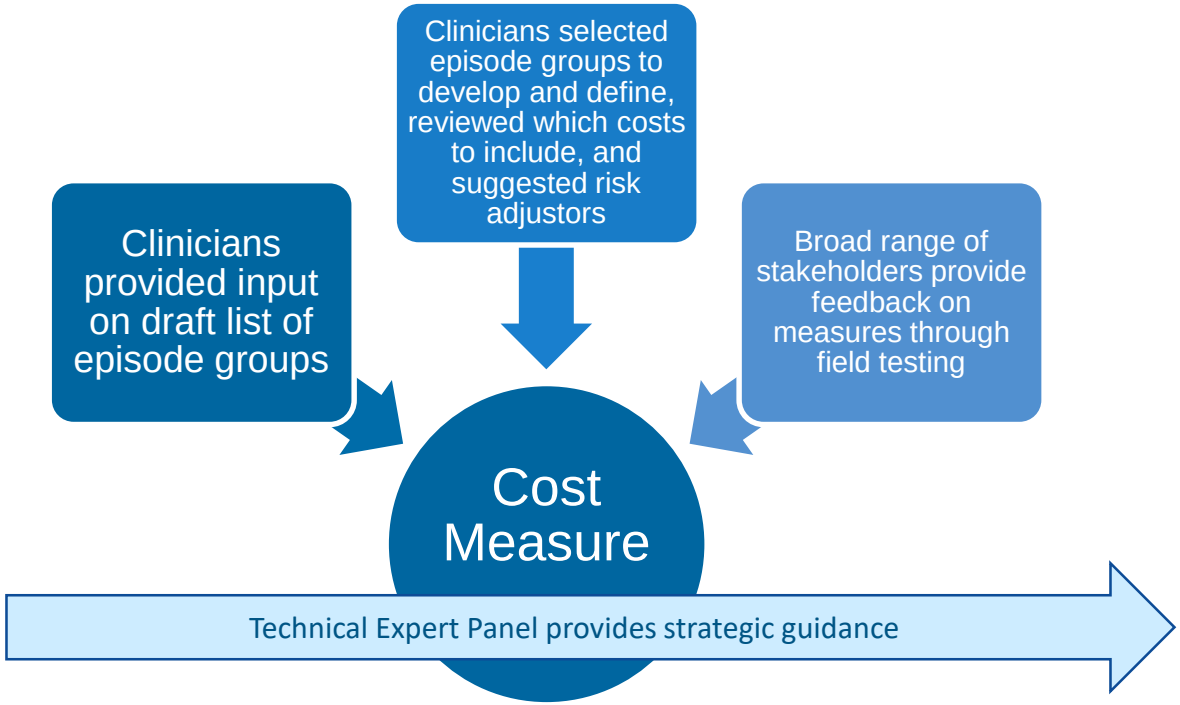
What is an Episode-Based Cost Measure?

- An episode-based cost measure represents Medicare payment for the medical care furnished to a patient during an episode of care, composed of 5 essential components:

1. **Defining an episode group**
   - Determine the codes that trigger (or open) an episode group and potential sub-groups
2. **Attributing the episode group to clinicians**
   - Determine the assignment of responsibility for an episode to a principal (or managing) clinician
3. **Assigning costs to the episode group**
   - Determine what services/costs are included in the episode by considering the role of the attributed clinician
4. **Risk adjusting episode groups**
   - Adjust for factors outside the clinician's control that can influence cost
5. **Aligning cost with quality**
   - Align with indicators of quality to compensate for information not adequately captured by episode costs

Approach to Episode-Based Cost Measure Development

- A broad range of stakeholders provide input on cost measures throughout development
- Acumen gathered input through a Technical Expert Panel, Clinical Committee and Subcommittees, measure-specific workgroups, Person and Family Committee, public comment, and field testing



Acumen Gathered Extensive Stakeholder Input To Date

Postings Related to CMS Episode Groups (Method A and B)

- CMS Episode Groups Posting (October 2015)
- Supplemental CMS Episode Groups Posting (April 2016)

Postings Related to Cost Measure Development

- Draft list of episode groups and trigger codes and accompanying document outlining cost measure development (December 2016)
- Operational list of care episode and patient condition codes and accompanying background document (January 2018)

Rulemaking

- CY 2017 Quality Payment Program Proposed Rule (May 2016)
- CY 2017 Quality Payment Program Final Rule with Comment Period (November 2016)
- CY 2018 Quality Payment Program Proposed Rule for Year 2 (June 2017)
- CY 2018 Quality Payment Program Final Rule for Year 2 with Comment Period (November 2017)
- CY 2019 Physician Fee Schedule Proposed Rule for the Quality Payment Program Year 3 (July 2018)

Acumen Gathered Extensive Stakeholder Input To Date

Technical Expert Panel

- Serves a high-level advisory role and provides guidance on overall direction of measure development
- 19 members, including from specialty societies, academia, healthcare administration, and patient and family member organizations
- Meetings in August 2016, December 2016, March 2017, August 2017, and May 2018

Clinical Committee (August - September 2016)

- Made recommendations about clinical specifications for episode groups
- Comprised over 70 clinicians from over 50 professional societies
- Provided expert input to develop draft list of episode groups and trigger codes

Clinical Subcommittees

- Measure development activities performed by the Clinical Subcommittees constitute the first and second waves of measure development, and as needed, the Subcommittees will continue developing additional measures
- Wave 1 (May 2017 – January 2018)
  - 7 Subcommittees comprising nearly 150 clinicians from nearly 100 professional societies
- Wave 2 (April 2018 – present)
  - 10 Subcommittees comprising 265 clinicians from 120 professional societies
  - From these Subcommittees, there are 11 measure-specific workgroups

Key Points from Stakeholder Feedback

- **Defining episode groups** and cost measures must yield actionable information that can guide improvements to patient care
- **Attribution** of claims and episodes to clinicians should be clear and credible at the time of service and should consider patient relationship
- **Assignment of costs to episode groups** should only hold clinicians accountable for patient outcomes that are within the scope implied by their clinical role
- Cost measures should account for patient complexity through appropriate **risk adjustment**
- Cost measures must be **aligned with quality measures** to promote delivery of high-quality and efficient care
- Broad **stakeholder feedback** is crucial to the development and implementation process, and more input will be solicited, including targeted stakeholder input that accomplishes the following:
  - Include adequate preparation materials and time, achieve greater transparency, avoid duplicating efforts among different activities, and incorporate feedback loops across Subcommittees

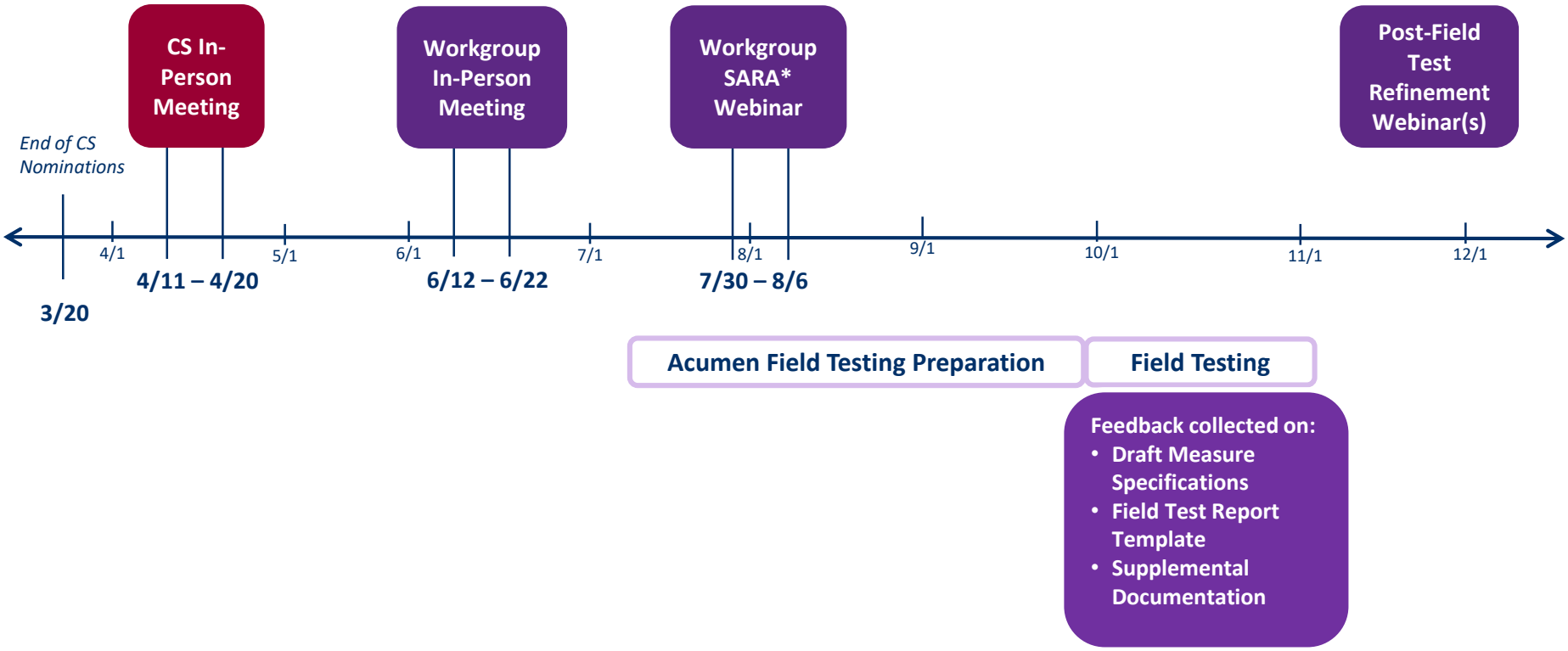
Wave 2 Clinical Subcommittees Have Developed Eleven Cost Measures

- CMS selected the 10 clinical areas for Wave 2 through consideration of input Acumen received from the TEP on prioritization of episode groups for development
- 10 Wave 2 Subcommittees selected 1-2 episode group(s) to develop into cost measures, and provided Acumen input on the scope of the episode group and composition of a smaller workgroup
  - 11 measure-specific workgroups provided detailed input on every component of the measure

Clinical Subcommittee	Episode-Based Cost Measure (Developed by Workgroup)
Cardiovascular Disease Management	Non-Emergent Coronary Artery Bypass Graft (CABG)
Gastrointestinal Disease Management - Medical and Surgical	Femoral or Inguinal Hernia Repair
	Lower Gastrointestinal Hemorrhage
Musculoskeletal Disease Management - Non-Spine	Elective Primary Hip Arthroplasty
Musculoskeletal Disease Management - Spine	Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels
Neuropsychiatric Disease Management	Psychoses/Related Conditions
Oncologic Disease Management – Medical, Radiation, and Surgical	Lumpectomy, Partial Mastectomy, Simple Mastectomy
Peripheral Vascular Disease Management	Hemodialysis Access Creation
Pulmonary Disease Management	Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
Renal Disease Management	Acute Kidney Injury Requiring New Inpatient Dialysis
Urologic Disease Management	Renal or Ureteral Stone Surgical Treatment

Wave 2 Clinical Subcommittee Timeline

April – December 2018



* Service Assignment and Risk Adjustment

RE-EVALUATED COST MEASURES

- MSPB Clinician Measure
- TPCC Measure

What is Measure Re-evaluation?

- Measures undergo re-evaluation as part of the measure maintenance process described in the CMS Blueprint
- Re-evaluation of MSPB clinician and TPCC measures has included stakeholder input
  - TEP provided Acumen high-level guidance on refinements for both measures at August 2017 and May 2018 meetings

MSPB Service Refinement Workgroup

- Provides detailed clinical input to refine the MSPB clinician measure by determining clinically unrelated services for exclusion
- Includes 25 members from 20 professional societies
- Two webinar meetings convened in summer of 2018

Overview of Re-evaluated Medicare Spending Per Beneficiary (MSPB) Clinician Measure

- Background:
  - The MSPB measure has been part of the MIPS cost performance category since the 2017 MIPS performance period[1]
  - Prior to its use in MIPS, CMS used a version of the MSPB measure in the Value Modifier Program and reported it in annual QRURs until the Value Modifier program was phased out
  - The MSPB clinician measure is now being re-evaluated before consideration of potential future use in MIPS
- Stakeholder feedback has suggested refining to:
  - Ensure attributed clinicians are responsible for a patient's care during an episode
  - Remove services not clinically related to the underlying reason for the index admission
- Note: This re-evaluated measure being field tested is separate from the measure used in the 2017 and 2018 MIPS performance periods. Field testing information about the re-evaluated MSPB clinician measure does not affect your MIPS score or payment adjustments

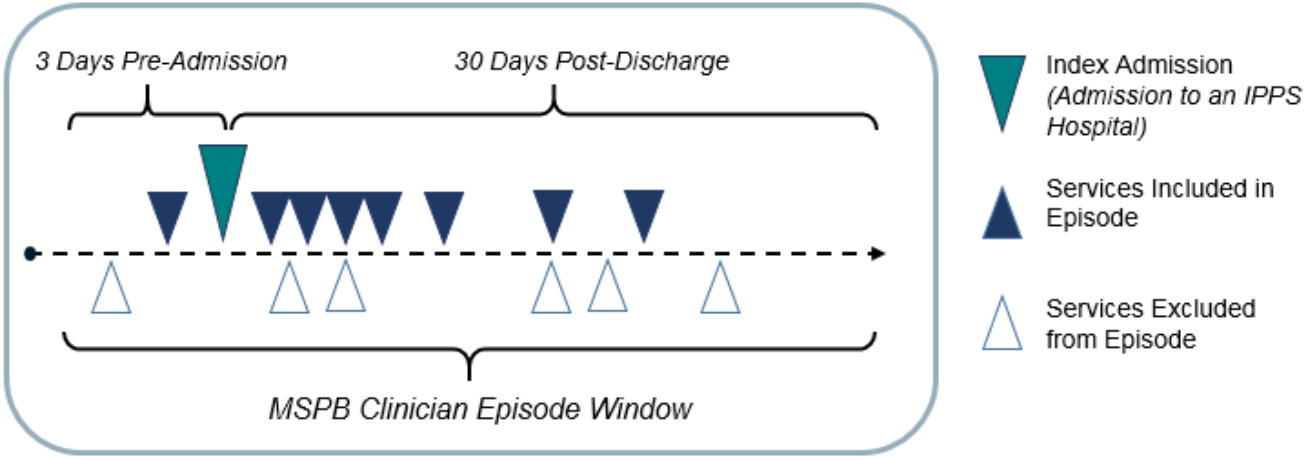
[1] "MSPB" alone refers to the measure as used in MIPS, and "MSPB clinician" refers to the re-evaluated measure being field tested

Refinements to Medicare Spending Per Beneficiary (MSPB) Clinician Measure

Refinement	MSPB measure in use for MIPS 2017	Re-evaluated MSPB clinician measure
Attribution	• Attributed first at the clinician (TIN-NPI) level	• Attributed first at the clinician group (TIN) level
	• Attributed each episode to the clinician billing the plurality of costs for Medicare Part B services rendered during an index admission	• Separate attribution methods for medical and surgical episodes: - Medical episodes: Attribute medical episodes to any clinician group that is responsible for managing the medical condition - Surgical episodes: Attribute surgical episodes to the surgeon performing the main procedure of an episode
Service Assignment	• All-cost measure that included all Medicare Part A and B claims paid during the period from three days prior to the index admission through 30 days after discharge	• Unrelated services excluded specific to groups of DRGs aggregated by MDC level • Examples include: - No orthopedic procedures for episodes triggered by DRG under Disorders of Gastrointestinal System (MDC 06 and MDC 07) - No valvular procedures for episodes triggered by DRG under Disorders of the Pulmonary System (MDC 04) - No hospice costs

Re-evaluated Medicare Spending Per Beneficiary (MSPB) Clinician Measure Background

- Episode cost sums standardized Medicare allowed amounts for Parts A and B services received by patient in an episode window surrounding admission to an acute inpatient hospital with exclusions for unrelated services



- MSPB clinician is the ratio of standardized observed cost to risk-adjusted expected cost averaged across all episodes attributed to clinician/clinician group and multiplied by the national average observed episode cost
- The measure can be attributed at the TIN or TIN-NPI level

Overview of Re-evaluated Total Per Capita Cost (TPCC) Measure

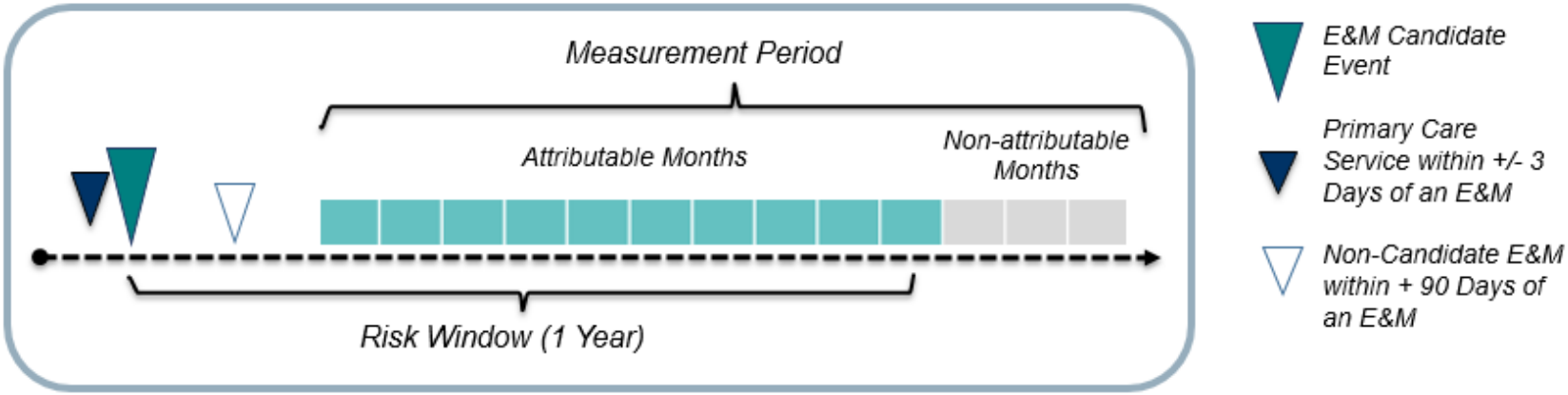
- Background:
  - The TPCC measure has been part of the MIPS cost performance category since the 2017 MIPS performance period
  - Prior to its use in MIPS, CMS used a version of the TPCC measure in the Value Modifier Program and reported it in annual QRURs until CMS phased out the Value Modifier program
  - The TPCC measure is now being re-evaluated before consideration of potential future use in MIPS
- Stakeholder feedback has suggested refining to:
  - Better identify a primary care relationship
  - Allow for multiple clinicians and clinician groups to be attributed responsibility for a patient's primary care management
- Note: This re-evaluated measure being field tested is separate from the measure used in the 2017 and 2018 MIPS performance periods. Field testing information about the re-evaluated TPCC measure does not affect your MIPS score or payment adjustments

Refinements to Total Per Capita Cost (TPCC) Measure

TPCC measure in use for MIPS 2017	Re-evaluated TPCC measure
• A beneficiary is attributed to the TIN-NPI from whom the beneficiary received the most primary care services (PCS). • If two TIN-NPIs tie for largest share of a beneficiary's PCS, the beneficiary is attributed to the TIN-NPI that provided the PCS most recently. • If the beneficiary did not receive a PCS from a primary care provider, the beneficiary is attributed to the non-primary care clinicians who provided the most PCS.	• New attribution method better identifies the existence of a primary care relationship between multiple clinician groups and beneficiaries, by requiring E&M services to have an associated primary care service or a follow up E&M service from the same clinician group - Allows for the attribution of episodes to multiple clinicians and clinician groups over the course of a performance period - Each attributable event initiates a one-year risk window during which a beneficiary's costs may be attributable to a clinician - Excludes clinicians who frequently perform certain non-primary care services (e.g., major surgeries) from attribution

Re-evaluated Total Per Capita Cost (TPCC) Measure Background

- A payment-standardized, risk-adjusted measure that evaluates the overall cost of care provided to beneficiaries attributed to clinicians



- TPCC is the sum of the risk-adjusted Medicare Part A and Part B costs across all episodes[1] attributed to a clinician/clinician group during the measurement period
- The measure can be attributed at the TIN or TIN-NPI level

[1] For TPCC, an episode is a month associated with a beneficiary during the measurement period that is attributable to a clinician.

FIELD TESTING

Updates from Oct - Nov 2017 Field Testing Feedback

- We appreciate the feedback stakeholders shared in field testing last year:
  - We posted a report summarizing all the feedback we received
  - The Clinical Subcommittees in Wave 1 considered feedback in refining the 8 episode-based measures that were field tested
  - We updated the field test report template for the TEP's consideration in May 2018
- For this year's field testing:
  - The measure specifications are shorter and easier to navigate
  - The field test reports contain more information to help you understand and improve your cost measure performance
    - Added a Glossary and an 'Understanding Your Report' tab
    - Incorporated tables for additional data elements stakeholders requested (e.g., breakdown of costs by pre-trigger, trigger event, and post-trigger)

Field Test Reports

- Clinicians and clinician groups attributed the following number of cases for at least one of the measures during the measurement period[1] have received a field test report with information about their cost performance:
  - 10 episodes for the 11 episode-based cost measures
  - 35 episodes for the MSPB clinician measure
  - 20 beneficiaries for the TPCC measure
- Stakeholders who received a field test report(s) can access the report(s) through the CMS Enterprise Portal
- Stakeholders who did not receive field test reports can view mock reports that are posted on the MACRA Feedback Page
- ***Documents:***
  - **Field Test Report (for clinicians and/or clinician groups who are attributed the minimum number of cases)**
  - **Mock Field Test Report**

[1] The measurement period for the episode-based cost measures and the MSPB clinician measure is January 1, 2017 through December 31, 2017. The measurement period for the TPCC measure is from October 1, 2016 through September 30, 2017.

Episode-Based Cost Measures Draft Measure Specifications

- Draft measure specifications are publicly posted on the MACRA Feedback Page
  - Measure development process document (PDF file)
  - Draft measure methodology for each measure (PDF file)
  - Draft measure codes list for each measure (excel file)
- The draft cost measure methodology should be reviewed with the corresponding draft measure codes list file to understand the full specifications of the cost measure
- The specifications reflect extensive input from the measure-specific workgroups and will be further refined based on feedback received during field testing
- ***Documents:***
  - **Measure Development Process document**
  - **Draft Cost Measure Methodology documents**
  - **Draft Measure Codes List files**

MSPB Clinician and TPCC Draft Measure Specifications

- Draft measure specifications for the MSPB clinician and TPCC measures are publicly posted on the MACRA Feedback Page
  - Draft measure methodology for each re-evaluated measure (PDF file)
  - Draft measure codes list for each re-evaluated measure (excel file)
- The draft cost measure methodology should be reviewed with the corresponding draft measure codes list file to understand the full specifications of the cost measure
- These specifications reflect extensive input from the TEP for both measures and the MSPB Service Refinement Workgroup for the MSPB clinician measure
  - Measure specifications will be further refined based on feedback received during field testing
- ***Documents:***
  - **Draft Cost Measure Methodology documents**
  - **Draft Measure Codes List files**

Supplemental Documentation

- Additional documents to supplement draft measure specifications and field test reports are publicly posted on the MACRA Feedback Page
- A short fact sheet that provides a high-level overview of field testing, with sections covering episode-based cost measures and re-evaluated cost measures
- A Frequently Asked Questions document that provides a comprehensive set of questions and answers related to field testing, with sections covering episode-based cost measures and re-evaluated cost measures
- ***Documents:***
  - **Fact Sheet**
  - **Frequently Asked Questions**

Online Field Testing Feedback Survey

- Stakeholder feedback will be collected through an online survey covering the episode-based cost measures and the re-evaluated cost measures being field tested
- To make it easy for all stakeholders to provide feedback, the survey will consist of:
  - Multiple choice/select answers
  - Free text responses
  - An option to skip all questions and attach a comment in PDF or Word format
- This survey will open on **October 3 and close on October 31, 2018 at 11:59pm ET**:

  https://www.surveymonkey.com/r/2018-macra-cost-measures-field-testing

ACCESSING THE FIELD TEST REPORTS

Accessing the Reports

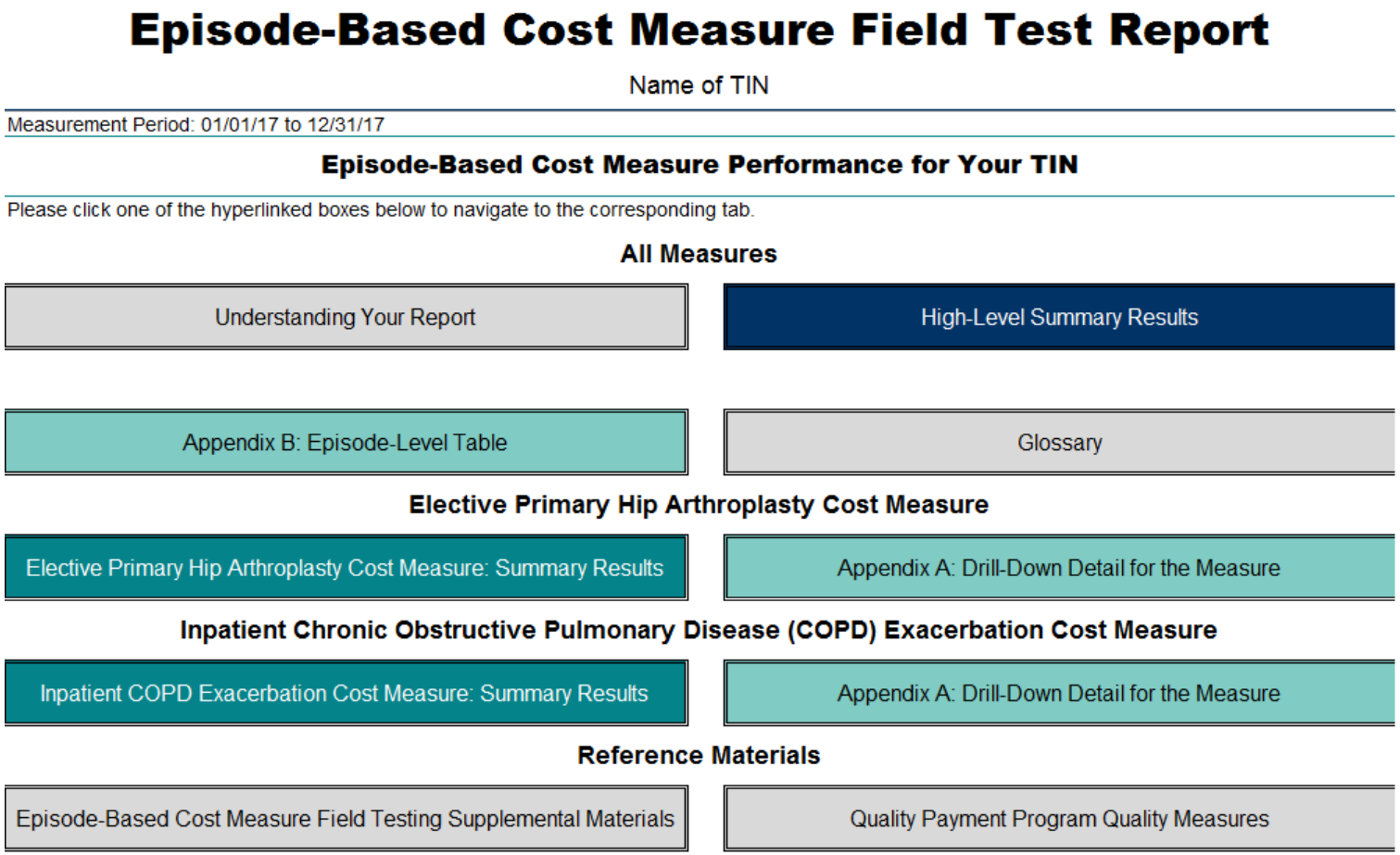
- If you or your clinician group meets are attributed the minimum number of cases for one or more of the episode-based cost measures under development, or one of the cost measures being re-evaluated, you may receive a report about your performance
- Reports will be distributed via the CMS Enterprise Portal.
- To access your report, make sure you have:
  - An active EIDM account, and
  - A 'Physician Quality and Value Programs' Role
- For step-by-step instructions on how to sign up for a new EIDM account, use this guide
- If you have an existing EIDM account, but need to ensure you have the appropriate role, use this guide
- You may also refer to the User Access Guide available on the MACRA Feedback page
- For questions about setting up an EIDM account or accessing your report, please contact: qpp@cms.hhs.gov or 1-866-288-8292

UNDERSTANDING THE FIELD TEST REPORTS

- Episode-Based Cost Measures
- MSPB Clinician Measure
- TPCC Measure

EPISODE-BASED COST MEASURES FIELD TEST REPORT

Overview of Episode-Based Cost Measure Field Test Report Structure



Episode-Based Cost Measure Field Test Report

Name of TIN

Measurement Period: 01/01/17 to 12/31/17

Episode-Based Cost Measure Performance for Your TIN

Please click one of the hyperlinked boxes below to navigate to the corresponding tab.

All Measures

Understanding Your Report | High-Level Summary Results

Appendix B: Episode-Level Table | Glossary

Elective Primary Hip Arthroplasty Cost Measure

Elective Primary Hip Arthroplasty Cost Measure: Summary Results | Appendix A: Drill-Down Detail for the Measure

Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation Cost Measure

Inpatient COPD Exacerbation Cost Measure: Summary Results | Appendix A: Drill-Down Detail for the Measure

Reference Materials

Episode-Based Cost Measure Field Testing Supplemental Materials | Quality Payment Program Quality Measures

- There are two versions of this field test report: (i) TIN and (ii) TIN-NPI
- The following slides in this section highlight key metrics found in these reports

High-Level Summary Results Tab

Average Episode Risk Score Percentile:

- Indicates on average, how expensive your episodes were expected to be relative to other TINs' episodes, as predicted through risk adjustment
- A lower percentile indicates that your episodes were on average expected to be among the least costly episodes across all TINs or TIN-NPIs, while a higher percentile indicates the opposite

Episode-Based Cost Measures					Cost Measure Score		
Type	Name	Short Form Name	Episode Count for Your TIN	Average Episode Risk Score Percentile	Your TIN	National Average	Percent Difference Between Your TIN's Average Risk-Adjusted Episode Cost and National Average Risk-Adjusted Episode Cost
Procedural	Elective Primary Hip Arthroplasty	el_ha	161	24th	$21,454	$19,154	12%
Acute IP Medical Condition	Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	ip_copd	1,053	75th	$12,483	$13,477	-7%

Summary Results for Cost Measure Tab

Breakdown of Utilization and Cost by Selected Clinical Theme

Clinical Theme:

- Clinical categorizations of services assigned during the episode window
- Created for the purpose of illustrating clinically important sources of episode spending in your feedback reports and providing actionable information to help improve care delivery
- Neither mutually exclusive nor exhaustive classifications of service utilization and costs

Clinical Theme	Your Average Cost Per Episode	Percent Difference in Average Cost of Clinical Theme Services for Your TIN Versus TINs in Your Risk Bracket	Share of Episodes with Any Cost From Given Clinical Theme		
			Your TIN	National Average	TINs in Your Risk Bracket
(1) Preoperative Work-Up	$116	52%	30.4%	87.0%	83.5%
(2) Post-Acute Care and Rehabilitation	$2,344	39%	80.1%	66.2%	62.1%

Summary Results for Cost Measure Tab

Breakdown of Utilization and Cost by Selected Clinical Theme

Risk Bracket:

- Provides a way of drawing more informative comparison between TIN-NPIs/TINs, as members of the same bracket are likely to have similar patient case-mix
- Constructed by dividing the distribution of average risk scores for all TINs/TIN-NPIs into deciles, with each decile corresponding to a risk bracket

Clinical Theme	Your Average Cost Per Episode	Percent Difference in Average Cost of Clinical Theme Services for Your TIN Versus TINs in Your Risk Bracket	Share of Episodes with Any Cost From Given Clinical Theme		
			Your TIN	National Average	TINs in Your Risk Bracket
(1) Preoperative Work-Up	$116	52%	30.4%	87.0%	83.5%
(2) Post-Acute Care and Rehabilitation	$2,344	39%	80.1%	66.2%	62.1%

Summary Results for Cost Measure Tab

Breakdown of Utilization and Cost by Selected Clinical Theme

Percent Difference in Average Cost of Clinical Theme Services for your TIN vs. TINs in your Risk Bracket:

- Highlights particular categories of services with clinical importance which may be more or less costly when they are billed in your TIN's episodes compared to TINs in your risk bracket

Clinical Theme	Your Average Cost Per Episode	Percent Difference in Average Cost of Clinical Theme Services for Your TIN Versus TINs in Your Risk Bracket	Share of Episodes with Any Cost From Given Clinical Theme		
			Your TIN	National Average	TINs in Your Risk Bracket
(1) Preoperative Work-Up	$116	52%	30.4%	87.0%	83.5%
(2) Post-Acute Care and Rehabilitation	$2,344	39%	80.1%	66.2%	62.1%

Appendices Tabs

- Appendix A:
  - Meant to supplement the information in each Results tabs
    - Provides more detailed information on potential cost drivers in the cost measure score
  - Breaks down your utilization and cost:
    - by Medicare setting and service category
    - for specific services from Part B Physician/Supplier Claims
    - for specific services from inpatient claims
  - These data are presented in comparison to TINs/TIN-NPIs in your risk bracket and the national average
- Appendix B:
  - Provides information at the episode-level for all episodes attributed to your TIN or TIN-NPI that were used in calculating your score for each cost measure
- Glossary:
  - Provides additional guidance to users for understanding the contents of each section of the Field Test Report

MSPB CLINICIAN MEASURE FIELD TEST REPORT

Overview of Medicare Spending Per Beneficiary (MSPB) Clinician Measure Field Test Report Structure

- There are two versions of the MSPB Clinician Measure Field Test Report: (i) TIN and (ii) TIN-NPI
- The MSPB Clinician Measure Field Test Reports contain the following sections:
  - Results
  - About the MSPB Clinician Measure Clinician Group (TIN) Report
    - For the TIN-NPI version: About the MSPB Clinician Measure Clinician (TIN-NPI) Report
  - Appendix A – MSPB Clinician Measure Score Calculation Breakdown
  - Appendix B – Glossary
- Each section has a hyperlink to the field testing feedback survey
- The following slides in this section highlight key tables you will find within these report sections

Results Section

Table 1: Your TIN/TIN-NPI's MSPB clinician measure score

- Table 1 details (i) your TIN/TIN-NPI's performance on the MSPB clinician measure, (ii) the national median, and (iii) your TIN/TIN-NPI's performance percentile rank nationally
- A lower score indicates that your episode costs are lower than or similar to the expected for the care provided for the particular patients and episodes included in the calculation, and a higher measure score indicates the opposite
- The percentile rank indicates the percentage of TINs/TIN-NPIs that received the same or higher MSPB clinician measure scores than your TIN/TIN-NPI

	MSPB Clinician Measure
Your TIN's score	$16,000
National Median	$18,696
Percentile Rank	95

	MSPB Clinician Measure
Your TIN-NPI's score	$18,741
National Median	$19,255
Percentile Rank	62

MSPB Clinician Field Test Report Tables

- In addition to your TIN/TIN-NPI's MSPB clinician measure score, the field test report includes additional detailed statistics to help you understand your performance
  - **Table 2: MSPB Clinician Cost Breakdown by Claim Type**
    - Shows how your episode cost by claim type compares to the state and national averages
  - **Table 3: MSPB Clinician Cost Breakdown by MDC**
    - Compares your episode costs by each MDC to the average expected cost calculated by the risk adjustment model
  - **Table 4: MSPB Clinician Cost Breakdown by Categories of Service**
    - Breaks down the per episode cost by service category
  - **Table 5: Statistics of Your TIN/TIN-NPI's MSPB Clinician Performance**
    - Provides more detailed statistics on your TIN/TIN-NPI's performance and allows you to follow the calculation of your measure score

TPCC MEASURE FIELD TEST REPORT

Overview of Total Per Capita Cost (TPCC) Measure Field Test Report Structure

- There are two versions of the TPCC Measure Field Test Report: (i) TIN and (ii) TIN-NPI
- The TPCC Measure Field Test Reports contain the following sections:
  - Results
  - About the TPCC Measure Clinician Group (TIN) Report
    - For the TIN-NPI version: About the TPCC Measure Clinician (TIN-NPI) Report
  - Appendix A – TPCC Measure Score Calculation
  - Appendix B – Glossary
- Each section has a hyperlink to the field testing feedback survey
- The following slides in this section highlight key tables you will find within these report sections

Results Section

Table 1: Your TIN/TIN-NPI's TPCC measure score

- Table 1 details (i) your TIN/TIN-NPI's performance on the TPCC measure, (ii) the national median, and (iii) your TIN/TIN-NPI's performance percentile rank nationally
- A lower score indicates that your episode costs are lower than or similar to the expected for the care provided for the particular patients and episodes included in the calculation, and a higher measure score indicates the opposite
- The percentile rank indicates the percentage of TINs/TIN-NPIs that received the same or higher TPCC measure scores than your TIN/TIN-NPI

	TPCC Measure
Your TIN's score	$891.95
National median	$755.38
Percentile rank	17

	TPCC Measure
Your TIN-NPI's score	$962.74
National median	$789.01
Percentile rank	18

TPCC Field Test Report Tables

- In addition to your TIN/TIN-NPI's TPCC measure score, the field test report includes additional detailed statistics to help you understand your performance
  - **Table 2: TPCC Cost Breakdown by Claim Type**
    - Shows how your episode cost by claim type compares to the state and national averages
  - **Table 3: TPCC Cost Breakdown by Specialty Type** (only available in the TIN –level report only)
    - Compares your episode costs by specialty type and also compares to your state and nationally
  - **Table 4: TPCC Breakdown by Categories of Service**
    - Breaks down the per episode cost by service category
  - **Table 5: Statistics of Your TIN/TIN-NPI's TPCC Performance**
    - Provides more detailed statistics on your TIN/TIN-NPI's performance and allows you to follow the calculation of your measure score

Q&A SESSION

Q&A Session Information

- [Insert call-in information for the Q&A Session]
- If there are additional questions, please direct the questions to: qpp@cms.hhs.gov or you can call at 1-866-288-8292

For More Information

- **MACRA Feedback Page**
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Feedback.html
- **Assistance with Accessing CMS Enterprise Portal**
  - Sign up for a new EIDM account using this guide: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Guide-for-Obtaining-a-New-User-EIDM-Account-with-a-Physician-Quality-and-Value-Programs-Role.pdf
  - Or to ensure that your existing EIDM account has the "Physician Quality and Value Programs" role, use this guide:
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Guide-for-Obtaining-Physician-Quality-and-Value-Programs-Role-for-Existing-EIDM-User.pdf

Information on Future Waves of Clinical Subcommittees

- Future waves of Clinical Subcommittees will be convened
- The Call for Subcommittee nominations will be posted here once the nomination period is open: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/TEP-Currently-Accepting-Nominations.html
- If you would like to be contacted when we open the nomination period for future Clinical Subcommittees, please provide your contact information on our mailing list here: https://www.surveymonkey.com/r/macra_clinical_subcommittee_mailing_list