

# Psychoses / Related Conditions Cost Measure Field Test Report

Name of Clinician Group

Taxpayer Identification Number (TIN): #####

Measurement Period: January 1, 2019 – December 31, 2019

## 1 MEASURE SCORE

This report shows your performance on the Psychoses / Related Conditions measure for field testing. Field testing is a chance for stakeholders to provide feedback on the cost measures being developed in 2021-2022. For more information about field testing, please refer to the [MACRA Feedback Page](#).<sup>1</sup>

The field testing period is from **January 10 to February 25, 2022**. To provide feedback on this measure, please navigate to the [2022 Cost Measures Field Testing Feedback Survey](#).

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**The information in this report is for field testing only. It doesn't affect any scoring or payment adjustments in the Merit-based Incentive Payment System (MIPS).** The information in this report is believed to be accurate at the time of production. The information may be subject to change at the discretion of the Centers for Medicare & Medicare Services (CMS), including but not limited to circumstances in which an error is discovered. Only clinicians (identified by their unique Taxpayer Identification Number [TIN] and National Provider Identifier [NPI] combination, or TIN-NPI) and clinician groups (identified by their TIN) with at least 20 episodes during the measurement period have received a field test report.<sup>2</sup>

<sup>1</sup> CMS, MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>.

<sup>2</sup> Individuals using assistive technology may not be able to fully access information in this file. To request a fully accessible report, contact [macra-cost-measures-info@acumenllc.com](mailto:macra-cost-measures-info@acumenllc.com).

## What is the Psychoses / Related Conditions Cost Measure?

The Psychoses / Related Conditions cost measure assesses care for patients who receive inpatient medical treatment for psychoses and related conditions. The measure identifies a patient-clinician relationship based on a Part B evaluation and management claim that occurred during an inpatient stay for psychoses and related conditions. Once the clinician-patient relationship is identified, this opens up a period of 45 days from the inpatient admission date where the TIN and TIN-NPI are being assessed for the patient's care.

The measure only includes clinically related costs for psychoses and related conditions, including the initial inpatient stay, routine management (such as outpatient psychotherapy), and consequences of care (such as readmissions). It doesn't include services that are clinically unrelated. In this report, "cost" generally means the Medicare allowed amount.<sup>3</sup> Costs are payment-standardized to facilitate comparisons of resource use. Payment standardization assigns a comparable allowed amount for the same service by removing geographic differences and payment adjustments from special Medicare programs, such as add-on payments for medical education.<sup>4</sup> In addition, the episode observed cost is also risk-adjusted to ensure fair comparisons. Risk adjustment neutralizes the effects of risk factors deemed to be outside of a clinician's influence (e.g., pre-existing conditions, age, or indicators of clinical severity).

Please refer to [Section 4](#) for more detail about the measure specifications.

## Your Field Testing Cost Measure Score

Table 1 shows how you performed on this measure in field testing. The score represents your average risk-adjusted cost to Medicare across all of your episodes for the Psychoses / Related Conditions measure. You can compare it to the national average score to see how you performed compared to all clinician groups with a least one Psychoses / Related Conditions measure episode. This is an inverse measure, so a lower score indicates a lower cost.

**Table 1: Your Field Testing Cost Measure Score**

	Psychoses / Related Conditions Measure
Number of Episodes	199
Your Cost Measure Score (TIN)	\$20,086
National Average Cost Measure Score	\$16,673
Your Cost Measure Score Percentile (TIN)	77

Note: Refer to the Glossary, [Table A1](#) for definitions of metrics

The score percentile shows where you rank among all clinician groups receiving a field test report. It represents the percentage of clinician groups that had an equal or lower risk-adjusted cost to Medicare. Since this is an inverse measure, a lower percentile means that you performed at a lower cost than more clinician groups. For example, if you're in the 25<sup>th</sup> score percentile, it means

<sup>3</sup> The Medicare allowed amount on Medicare claims data includes both Medicare and trust fund payments and any applicable patient deductible and coinsurance amounts.

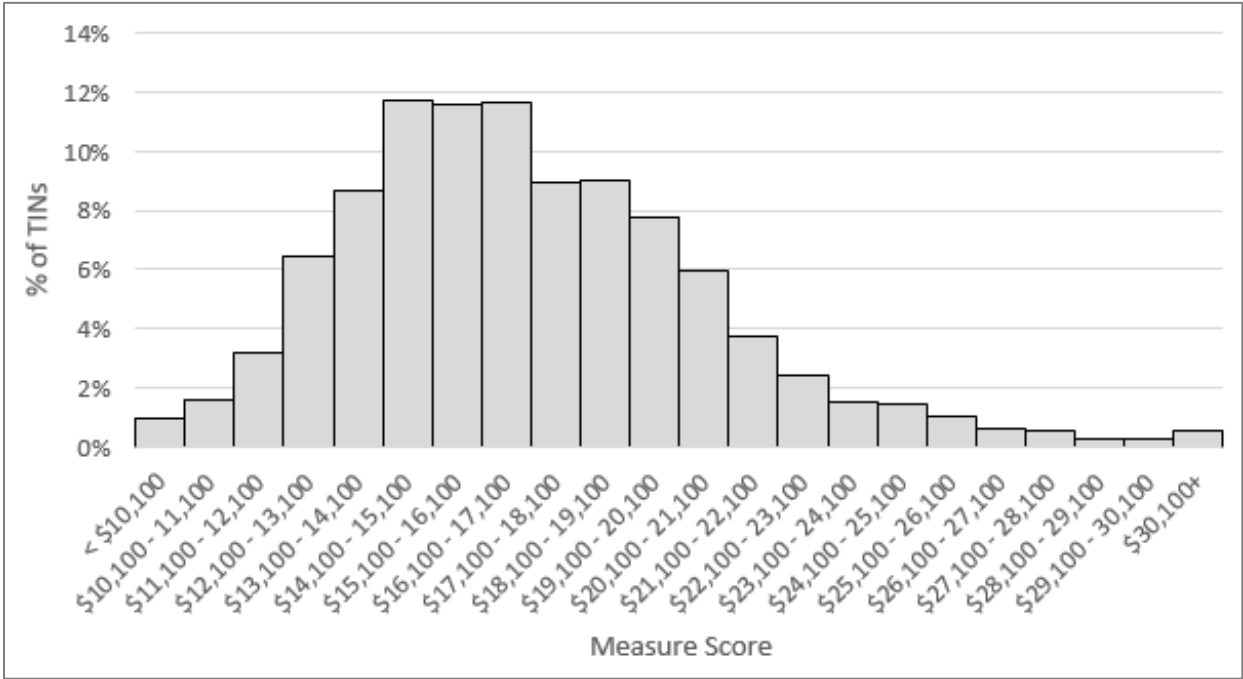
<sup>4</sup> CMS, Price (Payment) Standardization Overview, <https://www.resdac.org/articles/cms-price-payment-standardization-overview>.

that your score was lower and you performed at a lower cost than 75% of clinician groups for this measure.

**Histogram of National Cost Measure Scores**

Figure 1 shows a histogram of how clinician groups performed on the Psychoses / Related Conditions measure in field testing. Specifically, the distribution includes measure scores for all TINs with at least 20 Psychoses / Related Conditions measure episodes. There were 2,041 clinician groups that met this volume threshold in field testing.

**Figure 1: National Distribution of Field Testing Measure Scores**



## 2 BREAKDOWN OF COST MEASURE PERFORMANCE

There are many ways of looking at where costs are coming from in your measure. This section has information about types of services and clinicians who are contributing to your episode costs.

### Utilization and Cost of Different Types of Services

This section shows what types of costs are being captured by the measure. The tables show your performance compared with the national average and for TINs in your risk bracket. A risk bracket represents clinician groups likely to have a similar patient case-mix as you.

Risk brackets are constructed in several steps:

- We calculate a risk score for each episode that indicates the complexity of your patient.
  - It's calculated as the episode's expected cost (as predicted through risk adjustment) divided by the national average observed cost for the measure.
  - This yields a ratio, where a higher value indicates that the episode is expected to be more costly, based on the patient characteristics in the risk adjustment model.
- We then calculate your average risk score. This is the average of the risk scores for all your episodes.
- Finally, we create a distribution for the average risk score across all clinician groups with at least 20 episodes for this measure.
  - We divide the distribution into deciles to create risk brackets.
  - Each risk bracket has clinician groups who, on average, have a similar average episode risk score as you.

Table 2 provides a breakdown of service use and cost by setting and various categorizations. The table includes Medicare Parts A and B services. For Part B and outpatient services, the table uses the Restructured BETOS Classification System (RBCS). This is a taxonomy that allows researchers to group Medicare Part B healthcare service codes into clinically meaningful categories.<sup>5</sup>

You can use this table to see how often your episodes have particular services, and compare this to the national average and to clinician groups with a similar case-mix. You can also see the average observed cost of those services for all episodes with at least one service in a particular category.

To highlight services where your performance is more markedly different from clinician groups in your risk bracket, please refer to values with:

- An asterisk (\*), which indicates that your performance was more than 1 standard deviation above the average for clinician groups in your risk bracket; and
- A caret (^), which indicates that your performance was more than 2 standard deviations above the average for clinician groups in your risk bracket.

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<sup>5</sup> CMS, Restructured BETOS Classification System, <https://data.cms.gov/provider-summary-by-type-of-service/provider-service-classifications/restructured-betos-classification-system>.

**Table 2: Service Use and Cost by Medicare Setting and Service Category**

Medicare Setting and Service Category	Share of Episodes with ≥1 Service			Average Observed Cost of Services among Episodes with ≥ 1 Service		
	Your TIN	National Average	Your Risk Bracket	Your TIN	National Average	Your Risk Bracket
All Services	100.0%	100.0%	100.0%	\$18,989	\$17,362	\$15,376
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding Emergency Department)	58.2%	60.9%	54.5%	\$519	\$518	\$494
Outpatient Evaluation & Management Services	60.5%	60.6%	54.3%	\$316	\$494	\$473
Major Procedures	3.1%	9.9%	4.2%	\$2,111	\$1,785	\$1,877
Ambulatory/Minor Procedures	0.0%	6.3%	0.6%	\$0	\$234	\$161
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	0.0%	4.2%	3.2%	\$0	\$145	\$177
Ancillary Services	18.5%	28.0%	20.4%	\$98	\$117	\$111
Laboratory, Pathology, and Other Tests	15.8%	24.5%	17.3%	\$61	\$91	\$93
Imaging Services	3.8%	9.4%	5.8%	\$210	\$151	\$145
Durable Medical Equipment and Supplies	2.7%	6.4%	4.0%	\$152	\$421	\$273
Hospital Inpatient Services	100.0%	100.0%	100.0%	\$17,987	\$15,508	\$14,301
Facility Services: Trigger	100.0%	100.0%	100.0%	\$15,154	\$10,663	\$9,713
Facility Services: Non-Trigger	20.1%	38.4%	32.9%	\$20,616*	\$12,640	\$11,908
Physician Services During Hospitalization	100.0%	100.0%	100.0%	\$2,014	\$1,648	\$1,426
Emergency Department Services	26.5%	38.1%	38.0%	\$850	\$897	\$932
Emergency Evaluation & Management Services	26.5%	37.9%	37.8%	\$965	\$894	\$928
Procedures	0.1%	5.0%	6.2%	\$199	\$218	\$231
Laboratory, Pathology, and Other Tests	8.2%	9.3%	8.1%	\$12	\$11	\$10
Imaging Services	3.8%	9.7%	8.1%	\$54	\$40	\$40
Post-Acute Services	3.8%	29.3%	10.3%	\$6,454	\$8,765	\$5,571
Home Health	0.7%	13.1%	7.1%	\$3,548*	\$1,354	\$1,328
Skilled Nursing Facility	1.9%	27.6%	8.0%	\$4,981	\$10,596	\$8,821
Inpatient Rehabilitation or Long-Term Care Hospital	0.0%	7.6%	2.1%	\$0	\$14,873	\$13,780
All Other Services	83.2%	69.7%	60.0%	\$481	\$562	\$499
Ambulance Services	77.4%	60.0%	49.6%	\$456	\$498	\$488
Anesthesia Services	6.1%	14.7%	5.4%	\$1,251	\$718	\$674
Chemotherapy and Other Part B-Covered Drugs	5.3%	12.9%	10.7%	\$995*	\$237	\$243
Dialysis	2.1%	24.1%	8.0%	\$1081^	\$325	\$272
All Other Services Not Otherwise Classified	36.9%	31.2%	21.0%	\$311	\$341	\$214

**Notes:** Asterisk (\*): More than 1 standard deviation above the average for clinician groups in your risk bracket.

Caret (^): More than 2 standard deviations above the average for clinician groups in your risk bracket.

Refer to the Glossary, [Table A2](#) for definitions of metrics.

Table 3 provides a breakdown of service use and cost by clinical themes. Clinical themes are another way of categorizing the services that may be assigned in the measure.

**Table 3: Service Use and Cost by Psychoses / Related Conditions Clinical Theme**

Clinical Theme	Share of Episodes with ≥1 Service			Average Observed Cost of Services among Episodes with ≥ 1 Service		
	Your TIN	National Average	Your Risk Bracket	Your TIN	National Average	Your Risk Bracket
Outpatient Infusions, Laboratory, Imaging	15.7%	39.2%	27.7%	\$227	\$113	\$128
Outpatient Services & Psychotherapy	100.0%	98.7%	98.7%	\$1,585	\$1,354	\$1,232
Patient Transport	59.7%	49.5%	39.5%	\$139	\$321	\$339
Post-Acute Care and Ancillary Services	6.2%	27.5%	9.9%	\$5,890	\$9,888	\$6,186
Psychoses / Related Conditions Admission	100.0%	100.0%	100.0%	\$16,217	\$11,140	\$10,047
Readmissions / ED Visits	42.8%	49.3%	46.5%	\$14,850	\$9,850	\$8,928

**Notes:** Asterisk (\*): More than 1 standard deviation above the average for clinician groups in your risk bracket.

Caret (^): More than 2 standard deviations above the average for clinician groups in your risk bracket. Refer to the Glossary, [Table A3](#) for definitions of metrics.

### Clinicians Contributing to Your Episode Costs

Table 4 lists the clinicians that contributed the most to your Part B Physician/Supplier episode costs for the Psychoses / Related Conditions measure. The table is divided into columns for clinicians within and outside your TIN.

**Table 4: Top Clinicians Within and Outside Your TIN Contributing to Your Part B Physician/Supplier Episode Costs**

NPIs Within Your TIN	NPIs Outside Your TIN
(1) Name of Clinician - #####	(1) Name of Clinician - #####
(2) Name of Clinician - #####	(2) Name of Clinician - #####
(3) Name of Clinician - #####	(3) Name of Clinician - #####
(4) Name of Clinician - #####	(4) Name of Clinician - #####
(5) Name of Clinician - #####	(5) Name of Clinician - #####

Refer to the Glossary, [Table A4](#) for definitions of metrics

### 3 EPISODE COSTS

Your measure score reflects how you performed on at least 20 episodes. This section shows episode cost distributions and the share of your episodes in each of the measure sub-groups.

#### Your Risk-Adjusted Episode Costs

Table 5 shows how your risk-adjusted episode costs are spread out across the distribution. Risk-adjusted costs are costs that have been calculated to take into account risk factors such as patient health characteristics, age, reason for enrollment, and others.

**Table 5: Distribution of the Risk-Adjusted Costs for Your Episodes**

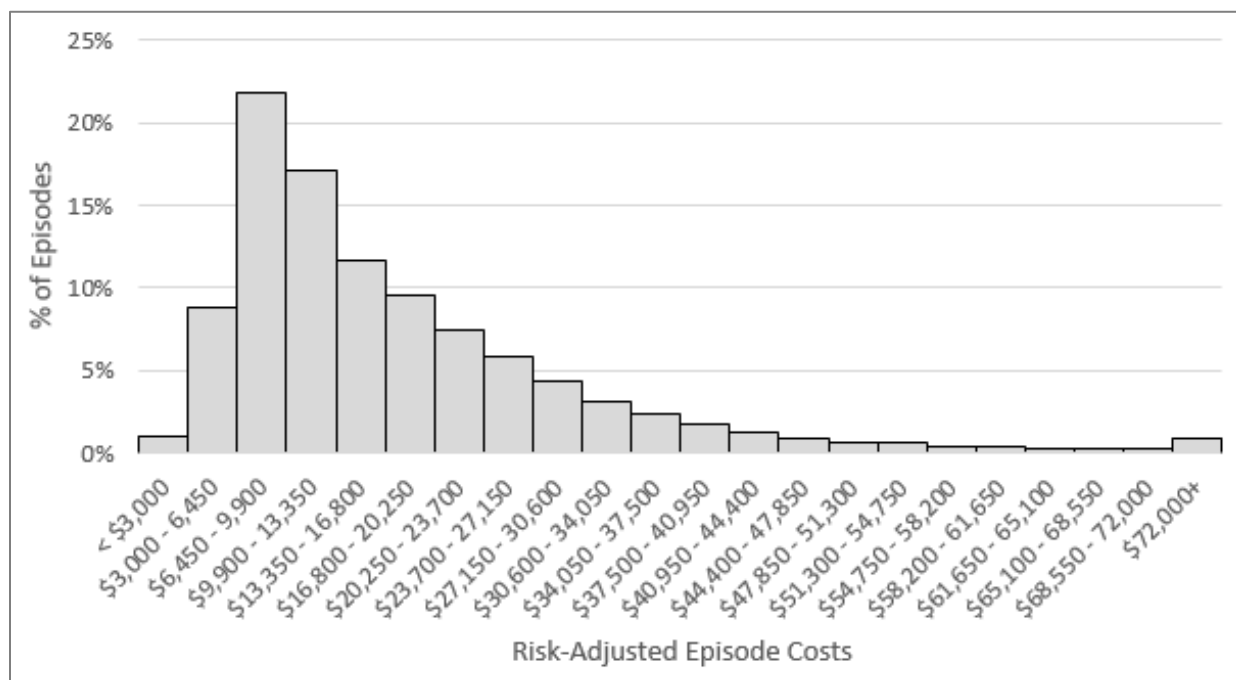
	Mean	Percentiles				
		5 <sup>th</sup> (Least Expensive)	25 <sup>th</sup>	50 <sup>th</sup> (Median)	75 <sup>th</sup>	95 <sup>th</sup> (Most Expensive)
Your Episodes	\$20,086	\$6,181	\$9,191	\$14,444	\$25,618	\$48,151

Refer to the Glossary, [Table A5](#) for definitions of metrics

#### Histogram of National Risk-Adjusted Episode Costs

Figure 2 shows a histogram of resource use for Psychoses / Related Conditions measure episodes in field testing. Specifically, the distribution includes risk-adjusted episode costs for all episodes among clinician groups with at least 20 Psychoses / Related Conditions measure episodes. Note that Figure 1 shows provider scores, whereas this figure is at the episode-level costs.

**Figure 2: National Distribution of Risk-Adjusted Episode Costs**



## Episode Sub-Groups

The Psychoses / Related Conditions measure is stratified into sub-groups. These represent clinically distinct patient cohorts and are defined to be mutually exclusive and exhaustive stratifications. The risk adjustment model is run separately within each sub-group. This means that episodes within each sub-group are only compared with other episodes within that same sub-group.

Table 6 shows how many of your episodes are within each sub-group. The table also shows your performance on episodes within each sub-group, represented by the mean ratio of observed to expected cost (as predicted through a risk adjustment model) across your episodes for each sub-group, alongside the national average for comparison.<sup>6</sup>

**Table 6: Breakdown of Episodes by Sub-Group**

Psychoses / Related Conditions Sub-Group	Number of Episodes	Share of Episodes		Mean Ratio of Observed to Expected Cost	
		Your TIN	National Average	Your TIN	National Average
<b>All</b>	199	100.0%	100.0%	1.32	0.96
Intellectual and Development Disorders with Psychosis	28	14.1%	8.0%	1.58	0.96
Dementia with Psychosis	0	0.0%	12.2%	0.00	0.94
Major Depressive Disorder with Psychosis	15	7.5%	9.1%	0.92	0.97
Mania or Bipolar with Psychosis	29	14.6%	10.6%	1.00	0.98
Schizophrenia Spectrum Disorders	61	30.7%	20.4%	0.99	0.97
Schizoaffective Disorders	48	24.1%	27.4%	1.02	0.97
Other Psychoses	18	9.0%	12.3%	1.00	0.99

Refer to the Glossary, [Table A6](#) for definitions of metrics

## Episode-Level File (CSV)

For the most granular information for each episode, you have an episode-level file in the same ZIP file as this report. This file lists each episode used to calculate your field testing measure score and provides information to help you understand the costs of care for each episode. It includes details to help you identify your patient and which providers furnished services during the episode of care. The file also has detailed breakdowns of what types of services in each episode counted towards your cost measure score. Finally, there's a data dictionary in the format of an excel workbook that has definitions for all metrics in the episode-level file.

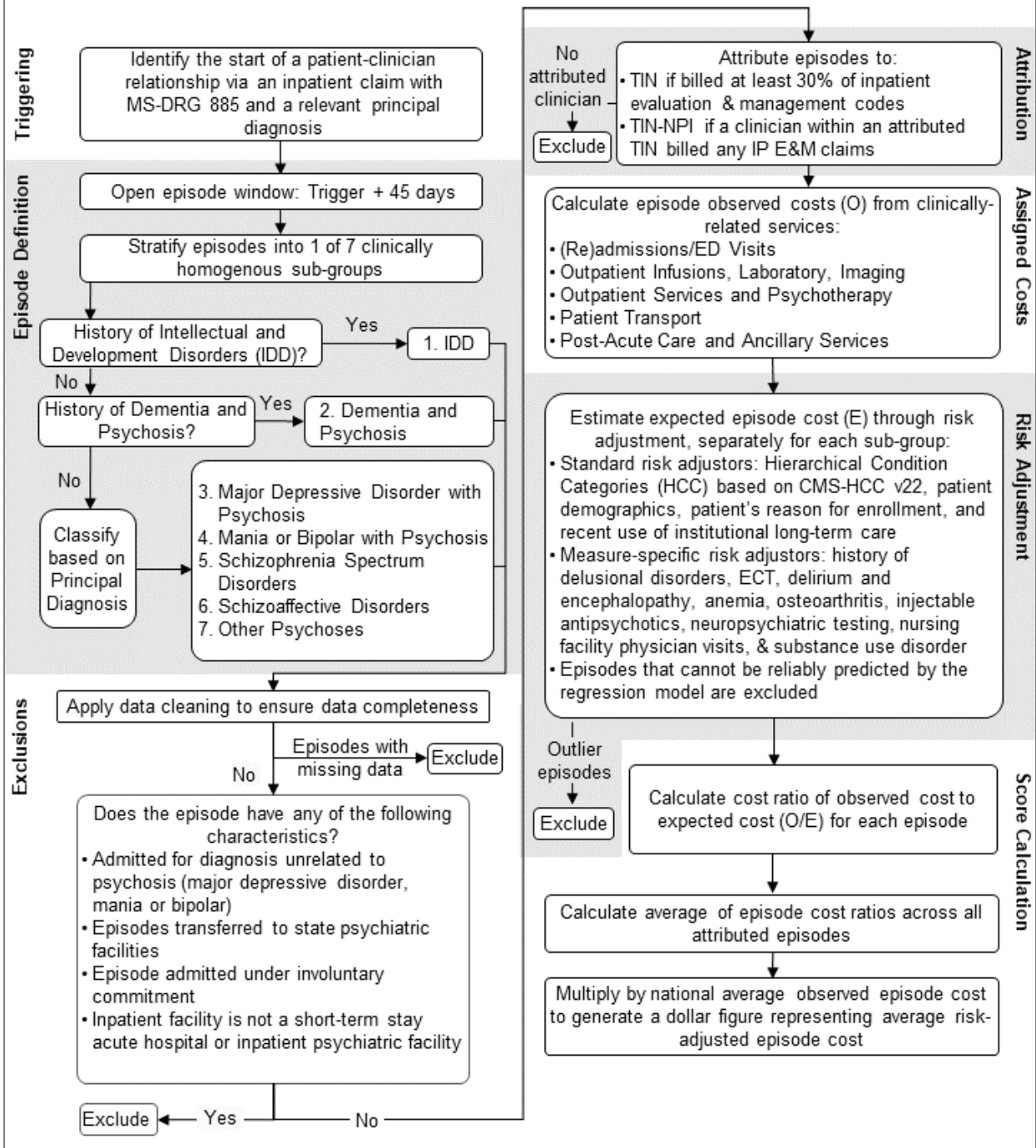
<sup>6</sup> Please note that we provide the mean ratio of observed to expected cost instead of your risk-adjusted cost for each sub-group, since ratios are more helpful when you analyze your performance across sub-groups.



## 4 ADDITIONAL INFORMATION

### Measure Flowchart

#### Psychoses / Related Conditions



## Where Can I Find More Information?

The [MACRA Feedback Page](#)<sup>7</sup> has all the field testing resources. Materials include:

- An online field testing survey (embedded in some of the field testing resources) where you can provide feedback about the measures,
- Frequently Asked Questions (FAQ),
- An overview of the measure development process,
- Draft measure specifications (Measure Information Form, Measure Codes List file), and
- Testing results.

If you have further questions, please contact the Quality Payment Program Service Center:

- Email: [gpp@cms.hhs.gov](mailto:gpp@cms.hhs.gov)
- Telephone: 1-866-288-8292, Monday – Friday, 8 a.m. – 8 p.m. ET
  - To receive assistance more quickly, please consider calling during non-peak hours – before 10 a.m. and after 2 p.m. ET.
  - Customers who are hearing impaired can dial 711 to be connected to a Telecommunications Relay Services Communications Assistant.

## Appendix A – Glossary

**Table A1: Definitions for Your Cost Measure Score Performance (Report: [Table 1](#))**

Term	Description
Number of Episodes	The number of episodes attributed to your TIN within the measurement period.
Your TIN's Cost Measure Score	Your TIN's average risk-adjusted cost for the measure. <u>Method of calculation:</u> The average ratio of observed cost to expected cost (as predicted through a risk adjustment model) across all your episodes, multiplied by the national average observed episode cost.
National Average Cost Measure Score	Average risk-adjusted cost across all clinician groups nationally for this episode-based cost measure. <u>Method of calculation:</u> The mean ratio of observed cost to expected cost (as predicted through a risk adjustment model) across all clinician groups nationally, multiplied by the national average observed episode cost. The mean ratio is calculated by taking the mean observed to expected ratio for each clinician group and then calculating the average of these ratios across all clinician groups.
Your TIN's Cost Measure Score Percentile	The percentile for your TIN's cost measure score among all cost measure scores for all clinician groups nationally. <u>Interpretation:</u> Higher values indicate that your episodes are relatively more expensive than episodes attributed to other clinician groups (and the inverse for lower values). <u>Example:</u> If your cost measure score percentile is in the 40 <sup>th</sup> percentile, then that means your cost measure score was higher than the scores for 40% of all clinician groups nationally and lower than the scores for 60% of all clinician groups. This is an inverse measure, so a lower score indicates a lower cost.

<sup>7</sup> CMS, MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>.

**Table A2: Definitions for Cost and Use by Medicare Setting and Service Category**  
(Report: [Table 2](#))

Term	Description
Medicare Setting and Service Category	The settings and service categories available from the claims data. This includes RBCS categorizations.
Share of Episodes with $\geq 1$ Service	<p><u>Your TIN</u>: The share of episodes with any cost from a setting/category across all episodes for your TIN.</p> <p><u>National Average</u>: The average share of episodes with any cost from a setting/category across all clinician groups nationally.</p> <p><u>TINs in Your Risk Bracket</u>: The share of episodes with any cost from a setting/category across all clinician groups in your risk bracket.</p>
Average Observed Cost of Services among Episodes with $\geq 1$ Service	<p><u>Your TIN</u>: The average cost of services from a setting/category across all episodes for your TIN. Note that this average is calculated out of all your TIN's episodes that include at least 1 service from the given setting/category.</p> <p><u>National Average</u>: The average cost of services for a setting/category across all episodes for all clinician groups nationally. Note that this average is calculated out of all episodes that include at least 1 service from the given setting/category.</p> <p><u>TINs in Your Risk Bracket</u>: The average cost of services for a setting/category across all episodes for clinician groups in your risk bracket. Note that this average is calculated out of all episodes that include at least 1 service from the given setting/category.</p>

**Table A3: Definitions for Cost and Use by Clinical Theme (Report: [Table 3](#))**

Term	Description
Clinical Theme	Clinical themes are clinical categorizations that organize all assigned services into broader categories. They are mutually exclusive and exhaustive of all service assignment rules, which were developed with input from the Psychoses / Related Conditions Clinician Expert Workgroup. To see which service assignment rules fall within each clinical theme, you may review the Draft Measure Codes List file for the measure.
Share of Episodes with $\geq 1$ Service	<p><u>Your TIN</u>: The share of episodes with any cost from a given clinical theme across all episodes for your TIN.</p> <p><u>National Average</u>: The average share of episodes with any cost from a given clinical theme across all clinician groups nationally.</p> <p><u>TINs in Your Risk Bracket</u>: The average share of episodes with any cost from a given clinical theme across all clinician groups in your risk bracket.</p>
Average Observed Cost of Services among Episodes with $\geq 1$ Service	<p><u>Your TIN</u>: The average cost calculated per episode for the clinical theme (i.e., for all billed items within that clinical theme). Note that this average is calculated out of all your episodes that include at least 1 service from the given clinical theme.</p> <p><u>National Average</u>: The average cost calculated per episode for the clinical theme out of all episodes for all clinician groups nationally (calculated only for episodes that include at least 1 service from the given clinical theme).</p> <p><u>TINs in Your Risk Bracket</u>: The average cost calculated per episode for the clinical theme out of all episodes for TINs in your risk bracket (calculated only for episodes that include at least 1 service from the given clinical theme).</p>

**Table A4: Definitions for Top Clinicians Within and Outside Your TIN Contributing to Your Part B Physician/Supplier Episode Costs (Report: [Table 4](#))**

Term	Description
NPIs Within Your TIN	List of the top 5 clinicians (i.e., NPIs) within your TIN that contributed the most Part B Physician/Supplier costs to your episodes.
NPIs Outside Your TIN	List of the top 5 clinicians (i.e., NPIs) outside your TIN that contributed the most Part B Physician/Supplier costs to your episodes.

**Table A5: Distribution of the Risk-Adjusted Costs for Your Episodes (Report: [Table 5](#))**

Term	Description
Risk-adjusted cost	This is the episode cost after accounting for risk factors deemed to be outside of a clinician group's influence (e.g., pre-existing conditions, age, or indicators of clinical severity). The episode cost is risk-adjusted to ensure fair comparisons and neutralize the effects of these risk factors. The distribution statistics of the risk-adjusted costs for your episodes are shown (including mean and various percentiles).

**Table A6: Definitions for Cost Measure Performance by Episode Sub-Group (Report: [Table 6](#))**

Term	Description
Episode Sub-Group	The episode sub-group. Episode sub-groups are mutually exclusive and exhaustive stratifications which means that episodes in each sub-group are only compared with other episodes within that same sub-group. Sub-grouping aims to enable meaningful clinical comparisons by allowing risk-adjustment models to be run separately for each sub-group.
Your Episode Count	The number of episodes attributed to your TIN within the measurement period for each sub-group.
Share of Episodes	<u>Your TIN</u> : Share of episodes (across all episodes for your TIN) by sub-group. <u>National Average</u> : Average share of episodes (for all clinician groups nationally) by sub-group.
Mean Ratio of Observed to Expected Cost	<u>Your TIN</u> : Your mean ratio of observed to expected cost (as predicted through a risk adjustment model) across your episodes for each sub-group. <u>National Average</u> : The mean ratio of observed to expected cost (as predicted through a risk adjustment model) across all clinician groups nationally for each sub-group. This is calculated by taking the mean observed to expected ratio for each clinician group and then calculating the average of these ratios across all clinician groups.