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# Merit Based Incentive Program (MIPS): Cost Category 2019 Overview

## Defining Cost and Strategies to Reduce Cost

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Managing Advisor Quality Services



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# Agenda

- 1) Overview of Quality Payment Program (QPP) Year 3 2019
- 2) Cost Performance Category Overview
- 3) Case Minimums, RAF, HCC
- 4) Scoring Cost Performance Category
- 5) Tips and Tools to Help Reduce Cost



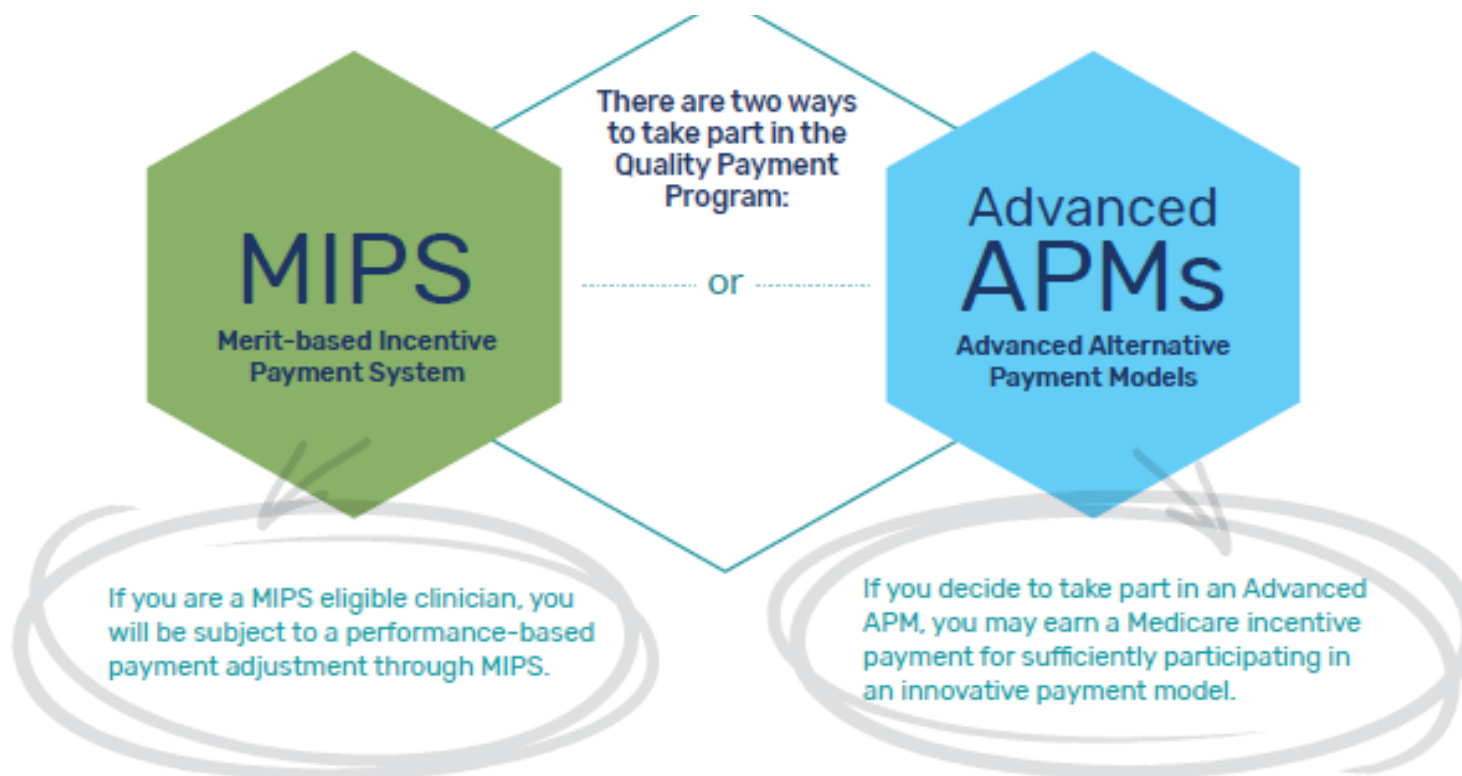
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# Overview of Quality Payment Program (QPP)2019



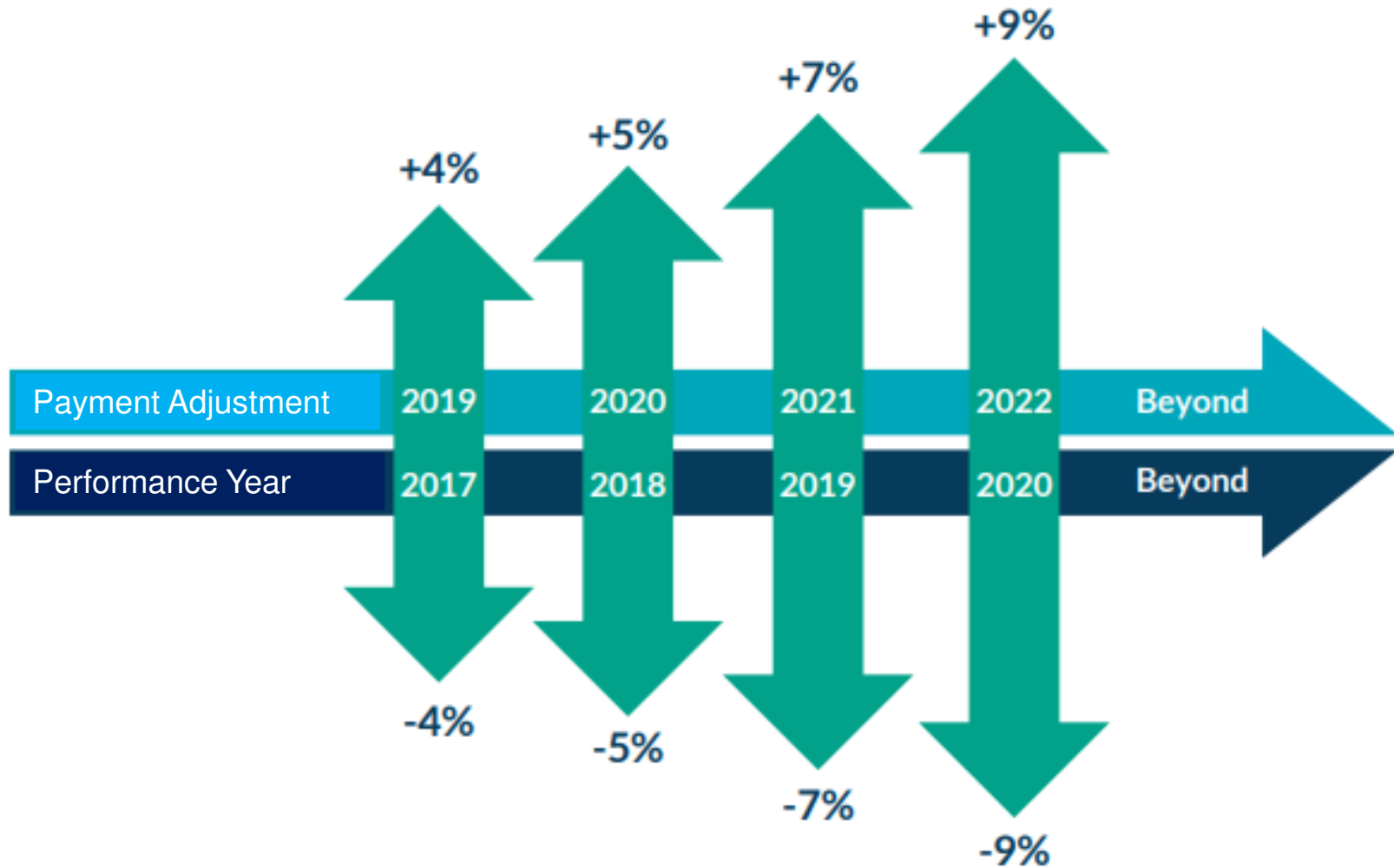
# MIPS 2019 Promoting Interoperability

## Two Participation Tracks



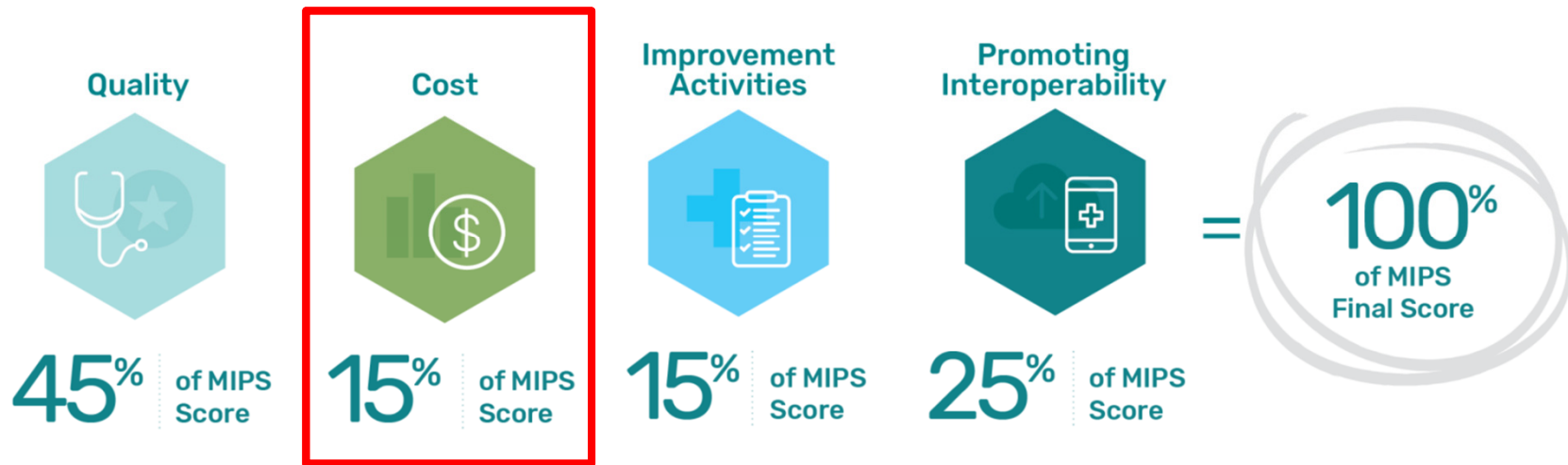
# Merit Based Incentive Payment System

## Payment Adjustment Schedule Based on Performance Year



# Merit Based Incentive Payment System

## MIPS Performance Categories



- Comprised of Four performance categories in 2019
- Points from each performance category are added together to give you a MIPS Final Score.
- MIPS Final Score is compared to MIPS performance threshold to determine if a **positive**, **negative**, or **neutral** payment adjustment is received.

# MIPS Year 3 - 2019

## Types of Clinicians Eligible to Participate 2018/ 2019

- Physicians
- Physicians Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- **Clinical Psychologists**
- **Physical Therapists**
- **Occupational Therapists**
- **Speech Language Pathologists**
- **Audiologists**
- **Registered Dieticians or Nutrition Professionals.**



*Bolded are **NEW** for 2019.*

# MIPS Year 3 - 2019

## Types of Clinicians Eligible - 2018/2019

### \*Physicians include:

- Doctors of Medicine
- Doctors of Osteopathy (including Osteopathic Practitioners)
- Doctors of Dental Surgery
- Doctors of Dental Medicine
- Doctors of Podiatric Medicine
- Doctors of Optometry
- Chiropractors - *legally authorized to practice by a State he/she performs this function.*



# MIPS Year 3 - 2019

## Low Volume Threshold Criteria (LVT)

New for 2019

\$90,000 a  
year Medicare  
Part B  
allowed  
charges

and

200 Medicare  
Beneficiaries

and

200 Covered  
Professional  
Services under  
PFS

- Bill >\$90,000 a year in allowed charges AND
- Provide care >200 Medicare beneficiaries AND
- Provide > 200 covered professional services under PFS.



**Note:** Must meet ALL 3 to be eligible for MIPS 2019.

# MIPS Year 3 - 2019

## Check Your Eligibility

Go to [www.qpp.cms.gov](http://www.qpp.cms.gov)

The screenshot shows the Quality Payment Program (QPP) website. At the top left, it says "Quality Payment PROGRAM". In the top right corner, there is a "MIPS ^" dropdown menu with "Merit-based Incentive Payment System" listed below it. The main content area features a large teal box with the text: "PERFORMANCE YEAR 2018 Submission Window is Open. You can now sign in to submit your data for PY 2018. You can submit and update your data any time until April 2, 2019, 8 pm EDT when the". To the right of this box is a navigation menu with two columns: "PARTICIPATION" and "MEASURES". Under "PARTICIPATION", there are links for "MIPS Overview", "Individual or Group Participation", "About MIPS Participation", "Exception Applications", and "How to Register for CMS Web Interface and CAHPS for MIPS Survey". Under "MEASURES", there are links for "Quality Measures Requirements", "Promoting Interoperability Requirements", "Improvement Activities Requirements", and "Cost Measures Requirements". Below the navigation menu are two buttons: "Check Participation Status" (highlighted with a red box and a red arrow pointing to the input field below) and "Explore Measures". Below the navigation menu, there is a section titled "QPP Participation Status" with the text: "Enter your 10-digit National Provider Identifier (NPI) number to view your QPP participation status by performance year (PY). QPP Participation Status includes APM Participation as well as Participation." At the bottom of this section is a form with an input field labeled "NPI Number" and a button labeled "Check All Years >".

# MIPS Year 3 - 2019

*If excluded, and still want to participate in MIPS?*

**Two options:**

**1. Voluntary**

- Submit data to CMS and receive performance feedback.

**2. Opt-in (*New for 2019*)**

- Available to EC's excluded from MIPS based on LVT.
- Meet or exceed **at least one**, but not all of LVT criteria.
- IF opt-in, subject to MIPS performance requirements, MIPS payment adjustment.

# MIPS Year 3 - 2019

## Submitting Your Data 2019\*

Go to [www.qpp.cms.gov](http://www.qpp.cms.gov)

MIPS Merit-based Incentive Payment System | APMs Alternative Payment Models | About The Quality Payment Program | Sign In Manage Account and Register

QPP Account

SIGN IN

REGISTER

Sign In

Submit and Manage Data

Sign in to QPP

USER ID

User ID

PASSWORD

Password

Show password

Forgot your user id or password? [Recover ID or reset password](#)

Sign in >

Don't have an account?

[Register](#)

\*Data Submission Deadline **March 31, 2020**

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# What Do I need to Understand about the Cost Category?

# Cost Performance Category 2019

- **15%** of Final Score in 2019
- No reporting requirement-data pulled and calculated from administrative claims for entire calendar year.
- 10 Measures:
  - Medicare Spending per Beneficiary (MSPB)
  - Total Per Capita Cost (TPCC)
  - Eight episode based measures.
- Cost data analyzed by individual NPI/TIN combo.



# Medicare Spending Per Beneficiary

## MSPB Measure

- The total Medicare Part A and Part B costs incurred by a single beneficiary during an “episode” and compares observed costs to expected costs.
- MSPB episode includes all Medicare Part A and B claims with start dates within episode window- 3 days before an index admission through 30 days after hospital discharge.



**Index Admission:** admission with principle diagnosis of a specified condition meeting inclusion and exclusion criteria.

# Medicare Spending per Beneficiary MSPB

## What is included in an MSPB episode?

Data source for Medicare Part A and B claim types for items and services included during the episode “window” are:

- Inpatient Hospital
- Outpatient
- Skilled Nursing Facility
- Home Health Hospice
- Durable Medical equipment, prosthetics, orthotics, and supplies (DMEPOS)
- Non-institutional physician/supplier claims (M'care Part B carrier claims)

*\*Prescription drug costs Part D are **NOT** included in calculation of MSPB measure.*



# Medicare Spending per Beneficiary MSPB

## MSPB Attribution

- Each Episode is “attributed” to a MIPS EC (NPI/TIN) providing the plurality or most Part B physician/supplier services measured by the dollar amount of M’care allowed charges-during the period between the index admission date and discharge date.
- Groups of clinicians participating as a “group”, a single measure score is calculated and assigned to group based on combined data.

# Medicare Spending per Beneficiary MSPB

## MSPB Attribution-continued

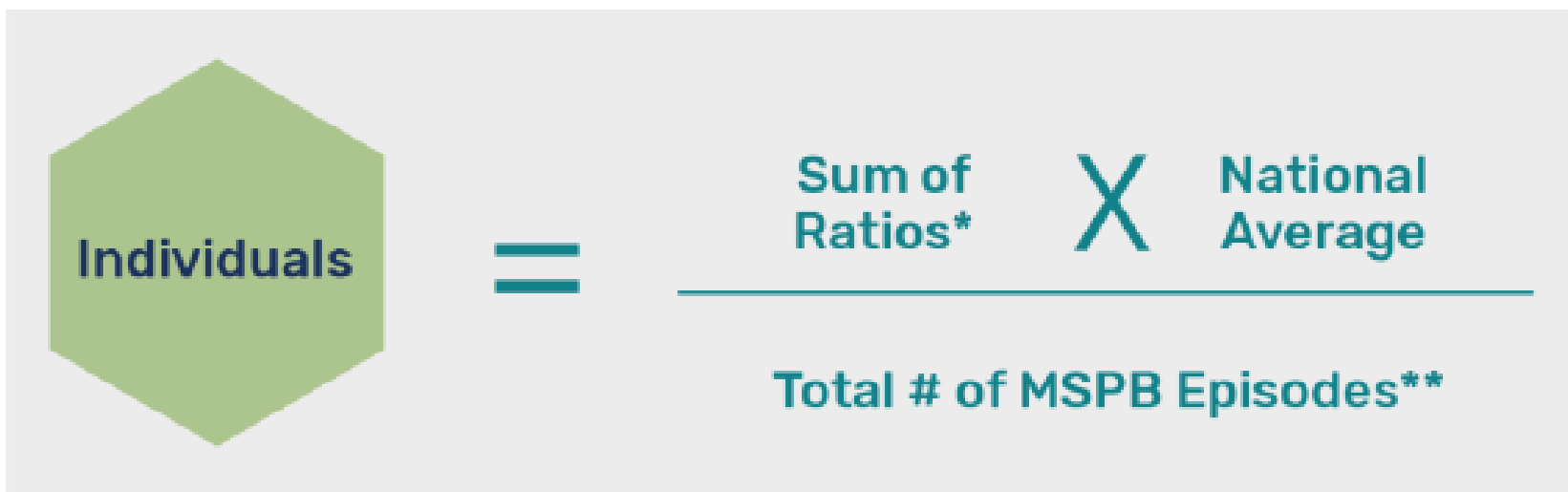
Attribution is determined on Part B services provided:

- Admission date and hospital setting with POS:
  - 21 (Inpatient)
  - 22 or 19 (Outpatient)
  - 23 (Emergency Department)
- During index hospital stay, regardless of POS
- Discharge date with POS restricted to Inpatient



# Medicare Spending per Beneficiary MSPB

## MSPB Calculation


$$\text{Individuals} = \frac{\text{Sum of Ratios}^* \times \text{National Average}}{\text{Total \# of MSPB Episodes}^{**}}$$

\*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

# Medicare Spending per Beneficiary MSPB

## Increasing your MSPB Score

- Know which clinicians your patients are seeing.
- Communicate with other clinicians about your patients.
- Focus on Quality measures and improvement activities that have a high impact on Cost measures.

**Example:** Quality measures related to All patient readmissions and Improvement Activities focused on improving this area, such as improving transitions of care and the associated Summary of Care exchange.

# Medicare Spending per Beneficiary MSPB

## Increasing your MSPB Score

- Care Coordination.
- Follow up and talk with your patients if admitted into ER.
- Educate patients on appropriate levels of care.
- When reviewing your data, keep in mind what the biggest drivers of cost.
  - Hospitalizations
  - ED Use
  - Readmissions
  - Use of post acute care services

# Total Per Capita Cost Measure

## Total Per Capita Costs-TPCC

- Risk and Specialty Adjusted
- Case Minimum 20

- Total Medicare Part A and B costs for beneficiaries attributed to the clinician with the **most allowed primary care services**, other than inpatient hospital, ER, and SNF during the reporting period.
- Payment-standardized, annualized, risk-adjusted, and specialty-adjusted measure.

# Total Per Capita Costs-TPCC

## Calculating TPCC

Sum of the annualized, risk-adjusted, specialty-adjusted Medicare Part A and Part B costs across all Medicare beneficiaries attributed to a TIN-NPI, within a TIN or TIN-NPI\*

# of all Medicare beneficiaries who received Medicare-covered services and are attributed to a TIN-NPI, within a TIN or TIN-NPI\* during the performance period



# Total Per Capita Cost Measure

## Measure Calculation Factors

TPCC Measure is calculated through the following steps:

- **Attribute** beneficiaries to individual TIN/NPIs.
- Calculate **payment standardized** per capita costs.
- **Annualize** costs for partial year enrolled Medicare beneficiaries included in measure.
- **Risk adjust** costs.
- **Specialty adjust** costs.

**Note:** IF a beneficiary is attributed to an FQHC or RHC CCN (CMS Certification Number), then that beneficiary is NOT included in the TPCC, and excluded from risk adjustment.



# Total Per Capita Cost Measure

## TPCC Attribution

### *Two step Attribution process:*

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

# Total Per Capita Cost-TPCC

## Increasing your TPCC Score

- Review your data at the patient level.
- Know which patients are attributed to you.
- Continue to monitor internal costs for beneficiaries who may be attributed to your TIN/NPI.
- Bill services correctly.
- Are you a specialist? Make sure your patients see their PCP.
- If you are a PCP, make sure you schedule annual wellness appointments.
- Be aware of your patient population and their needs.

# NEW 8 Episode Based Cost Measures

## Overview

### Episode Based Measures-

- Only include items and services that are related to the *episode of care* of a **clinical condition** or **procedure** (defined by procedure and diagnosis codes)
- Assess cost of the care that's clinically related to initial treatment of a patient and provided during an episode's time frame.
- Same as MSPB and TPCC, Episode Based measures are calculated using Medicare Parts A & B fee-for-service (FFS) claims data.



## 8 Episode Based Cost Measures

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

# NEW 8 Episode Based Cost Measures

## Episode Groups

- Represent a clinically cohesive set of medical services rendered to treat a given medical condition, **and**
- Aggregate all items and service provided for a defined patient cohort to assess the total cost of care.

**Episode Groups** consist of the following components:

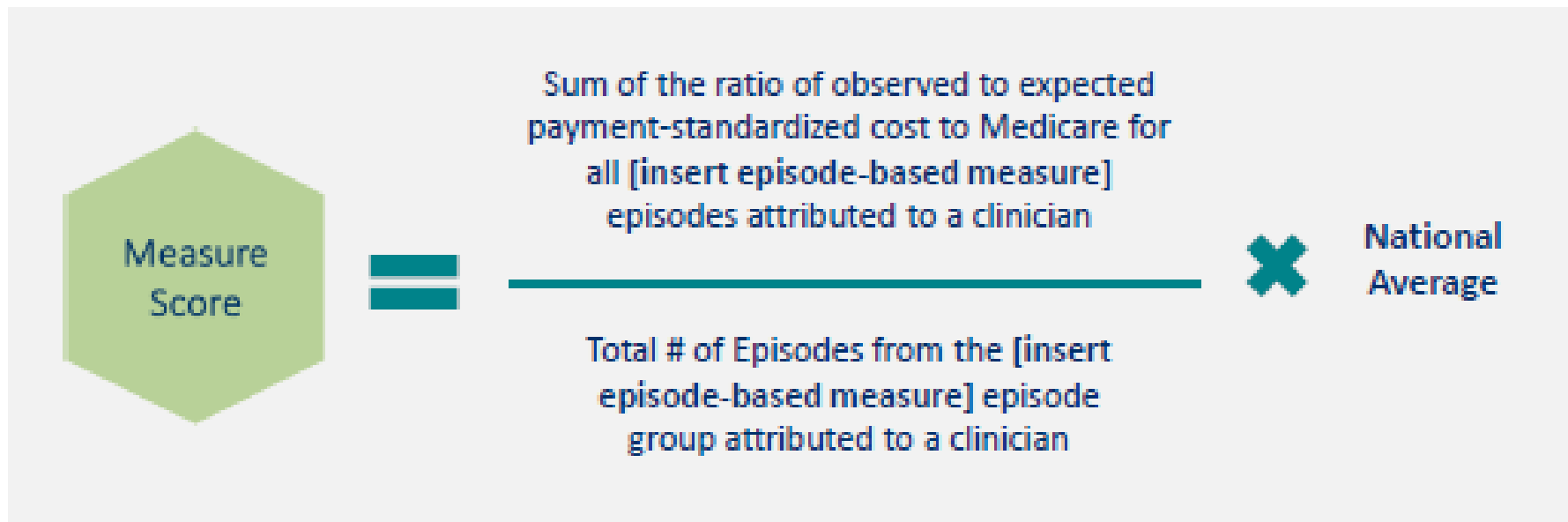
- Episode triggers and windows
- Item and Service assignment
- Exclusions
- Attribution methodology
- Risk Adjustment variable

*\*Detailed Methodology documents for each Episode Based Cost Measure can be found in a zip file in [QPP Resource Library](#).*

# NEW 8 Episode Based Cost Measures

## Measure Calculation

Example of the numerator and denominator for Episode Based Measure.



# NEW 8 Episode Based Cost Measures

## Tips To Maximize Your Score

- Do the episode based measures align with your specialty?
- Understand how these measures differ from MSPB.  
*i.e. simple pneumonia*
- Evaluate your processes related to the cost associated with these episode based measures. Review related quality measures and improvement activities to reduce costs in conjunction with quality improvement efforts.
- Specialists-take advantage of these measures to earn a high cost score.

**Note:** *episode based measures may be added in future that could align with your specialty.*

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# Case Minimums, Risk Adjustment Factor, and Hierarchical Condition Category





# Scoring Cost Performance Category

## Must Meet or Exceed Case Minimum

Measure	Case Minimum
Total Per Capita Cost (TPCC)	20
Medicare Spending Per Beneficiary (MSPB)	35
Procedural Episodes	10
Acute Medical Condition Episodes	20

- TPCC < 20 not scored.
- MSPB <35 not scored OR did not bill Part B services in hospital stays during performance period.
- Procedural Episodes <10 not scored.
- Acute Medical Condition Episodes .<20 not scored.

# 2019 Cost Performance Scoring

## Case Minimum and Reweighting

- If you don't meet the case minimums to be scored on any of the cost measures, your performance on Cost will count toward **0%** of your MIPS Final Score
- The weight of your Quality score will increase from **45% to 60%** of your MIPS Final Score
- **Pay attention:** Are you meeting the case minimum? If not, this will have an impact on your quality score!

# Risk Adjustment Factor (RAF)

## Define RAF



- Tool used to estimate expected costs per beneficiary.
- Uses demographics, age, severity or “disease burden”, and ICD-10 codes.
- Medicare Advantage Plans and many commercial payors utilize RAF scores for reimbursement purposes.
- Uses Hierarchical Condition Categories (HCC) provides a snapshot into a patients illness by severity.

# Hierarchical Condition Category-HCC

## Coding to Specificity



- Sorting mechanism for chronic conditions that assigns a value on care for a patient.
- Provides “snapshot” into a patients disease complexity providing insurers valuable info to assess outcomes, determine payment rates, and gauge overall hospital performance..
- ICD codes are mapped to exactly one HCC.
- Factor into the risk adjustment scores to predict future costs.
- HCCs must be captured once every 12 months.

# HCC-RAF Example

Source	Description	RAF	Source	Description	RAF
HCC 1	HIV/AIDS	0.470	HCC 55	Drug/Alcohol Dependence	0.420
HCC 2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	0.535	HCC 57	Schizophrenia	0.490
HCC 6	Opportunistic Infections	0.440	HCC 58	Major Depressive, Bipolar, and Paranoid Disorders	0.330
HCC 8	Metastatic Cancer and Acute Leukemia	2.484	HCC 70	Quadriplegia	1.234
HCC 9	Lung and Other Severe Cancers	0.973	HCC 71	Paraplegia	1.052
HCC 10	Lymphoma and Other Cancers	0.672	HCC 72	Spinal Cord Disorders/Injuries	0.509
HCC 11	Colorectal, Bladder, and Other Cancers	0.317	HCC 73	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	0.958
HCC 12	Breast, Prostate, and Other Cancers and Tumors	0.154	HCC 74	Cerebral Palsy	0.045
HCC 17	Diabetes with Acute Complications	0.368	HCC 75	Myasthenia Gravis/Myoneural Disorders and Guillain-Barr Syndrome/Inflammatory and Toxic Neuropathy	0.408
HCC 18	Diabetes with Chronic Complications	0.368	HCC 76	Muscular Dystrophy	0.565
HCC 19	Diabetes without Complication	0.118	HCC 77	Multiple Sclerosis	0.556
HCC 21	Protein-Calorie Malnutrition	0.713	HCC 78	Parkinson's and Huntington's Diseases	0.691
HCC 22	Morbid Obesity	0.365	HCC 79	Seizure Disorders and Convulsions	0.284
HCC 23	Other Significant Endocrine and Metabolic Disorders	0.245	HCC 80	Coma, Brain Compression/Anoxic Damage	0.570
HCC 27	End-Stage Liver Disease	0.923	HCC 82	Respirator Dependence/Tracheostomy Status	1.520

# Hierarchical Condition Category

## Example of ICD-10 code-HCC Group RAF

ICD-10-CM Code	Description	HCC Group	Risk Adjusted Factor
F32.9	Major depressive disorder, single episode, unspecified	0	0.00
F32.0	Major depressive disorder, single episode, mild	58	0.395



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# How is Cost Calculated?



# How is Cost Calculated?



Individual EC's must have enough attributed cases to meet or exceed case minimum for that cost measure.

- If **only one** measure can be scored, that will be the Cost Performance category score.
- If **multiple** cost measures are scored, score is equally weighted average of all the scored measures.
  - *Example: if 7 out of 10 cost measures are scored, the cost performance score is the equally weighted avg. of the 7 scored measures.*
- IF **none** of the 10 cost measures can be scored, cost performance score will be 0%, and Cost will be reweighted to Quality, which is  $45\% + 15\% = 60\%$ .



# Cost Scoring Example

Measure	Measure Achievement Points Earned by the Group	Total Possible Measure Achievement Points Available
TPCC Measure	8.2	10
MSPB Measure	6.4	10
Elective Outpatient PCI Measure	Not scored	N/A-not scored
Knee Arthroplasty Measure	7	10
Revascularization for Lower Extremity Chronic Critical Limb Ischemia Measure	5.5	10
Routine Cataract Removal with IOL Implantation Measure	9	10
Screening/Surveillance Colonoscopy Measure	Not scored	N/A-not scored
Intracranial Hemorrhage or Cerebral Infarction Measure	4.8	10
Simple Pneumonia with Hospitalization Measure	6.7	10
STEMI with PCI Measure	Not scored	N/A-not scored
<b>TOTAL</b>	<b>47.6</b>	<b>70</b>

Cost performance category score is  $(47.6/70=0.68)$ , which is equal to a Cost performance category percent score of 68%. Cost performance category =15 points, group would earn 10.2 points towards their final score  $(68 \times .15=10.2)$

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# Tips and Tools to Help Reduce Cost



# Tools to Help with Cost

## Cost Makes a Difference

- Hardest to change and least understood.
- Look at your data.
- Plan your transitions of care.
- Choose referring providers.
- Careful documentation.
- Category weight is increasing and will have a greater impact year to year.



# Tips For Success in Cost Category

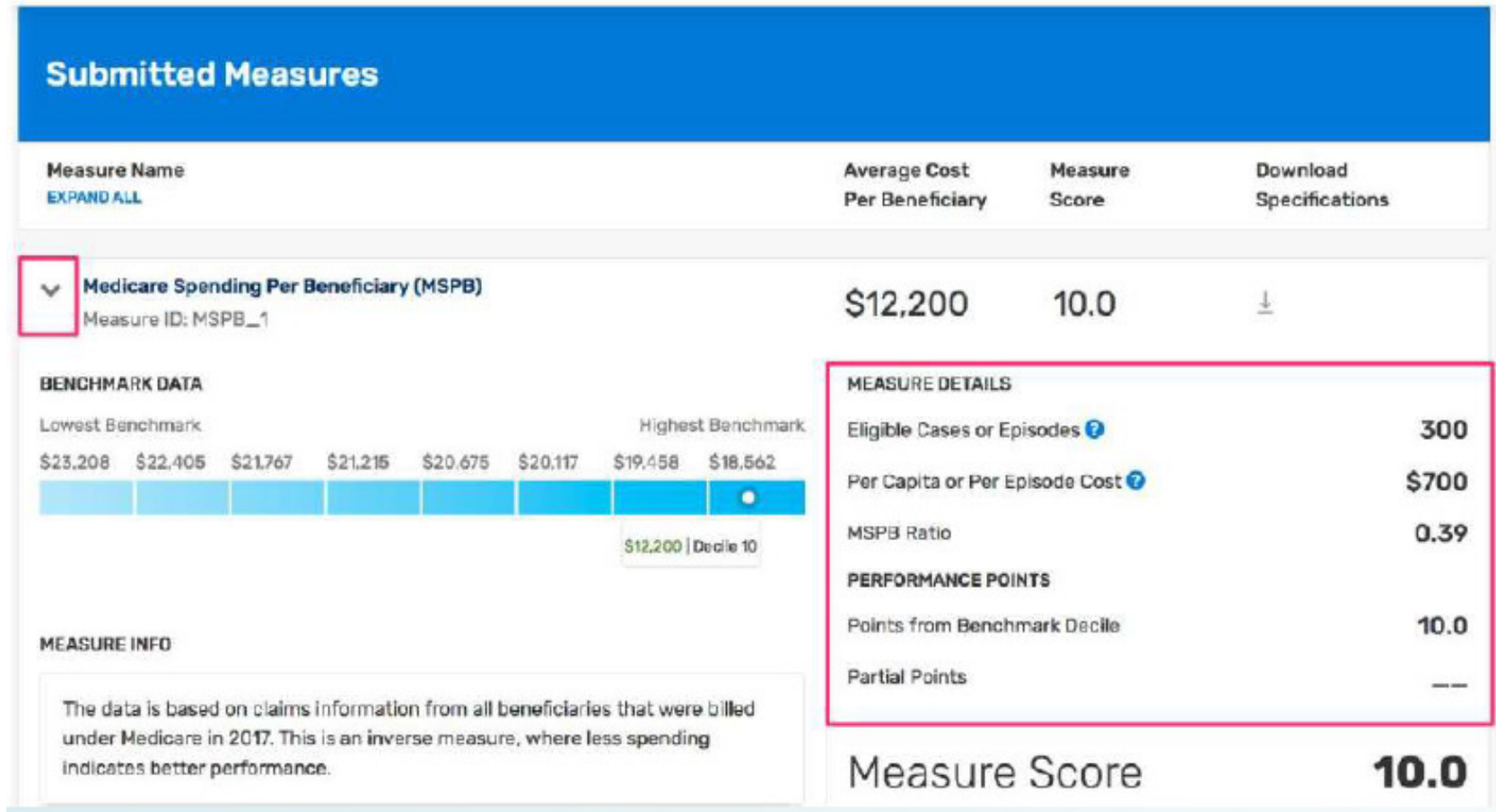
- Review Performance Feedback Reports. Did you meet case minimum? 2018 Feedback Reports available July 2019!
- Look at your incoming Summary of Care info from specialties in your area and see where patients have been.
- Partner with local hospitals to receive daily reports of your patients that have gone to the ER or hospitalized.
- Commitment to continuous performance improvement.
- Coding to specificity. (HCC coding and ICD-10)
- AWW, CCM, TCM



**START NOW! DO NOT WAIT!**

# MIPS 2017 Performance Feedback Report

## Cost: MSPB



# Quality Payment Program Resources

[www.qpp.cms.gov](http://www.qpp.cms.gov)

Quality Payment  
PROGRAM

MIPS  
Merit-based Incentive  
Payment System

APMs  
Alternative Payment  
Models

About  
The Quality  
Payment Program

Sign In  
Manage Account  
and Register

## Resource Library

### Full Resource Library

Search   - Hide filters

Performance Year	QPP Reporting Track	Performance Category	Resource Type
2019	MIPS	Cost	All

[Clear all filters](#)

4 Resources Alphabetical Latest

↓ [2019 Cost Performance Category Fact Sheet](#) Updated 12/28/2018  
PDF 1MB | PY 2019 | MIPS | Cost | Fact Sheets

Discusses the Merit-based Incentive Payment System (MIPS) Cost performance category and provides details on the Total Per Capita Costs for All Attributed Beneficiaries measure (TPCC) and the Medicare Spending Per Beneficiary measure (MSPB), as well as the eight new episode-based measures.

↓ [2019 Cost Measure Information Forms](#) Updated 12/27/2018  
ZIP 9MB | PY 2019 | MIPS | Cost | Measure Specifications and Benchmarks

Details the measure methodology for each of the 8 episode-based cost measures that are new for the Cost performance category in 2019 and provides an overview of the 2019 TPCC and MSPB cost measures that were established for the Merit-based Incentive Payment System (MIPS) in 2018.

- QPP Overview
- Help and Support
- [Resource Library](#)
- Webinar Library
- Small, Underserved, and Rural Practices
- Timeline and Important Deadlines

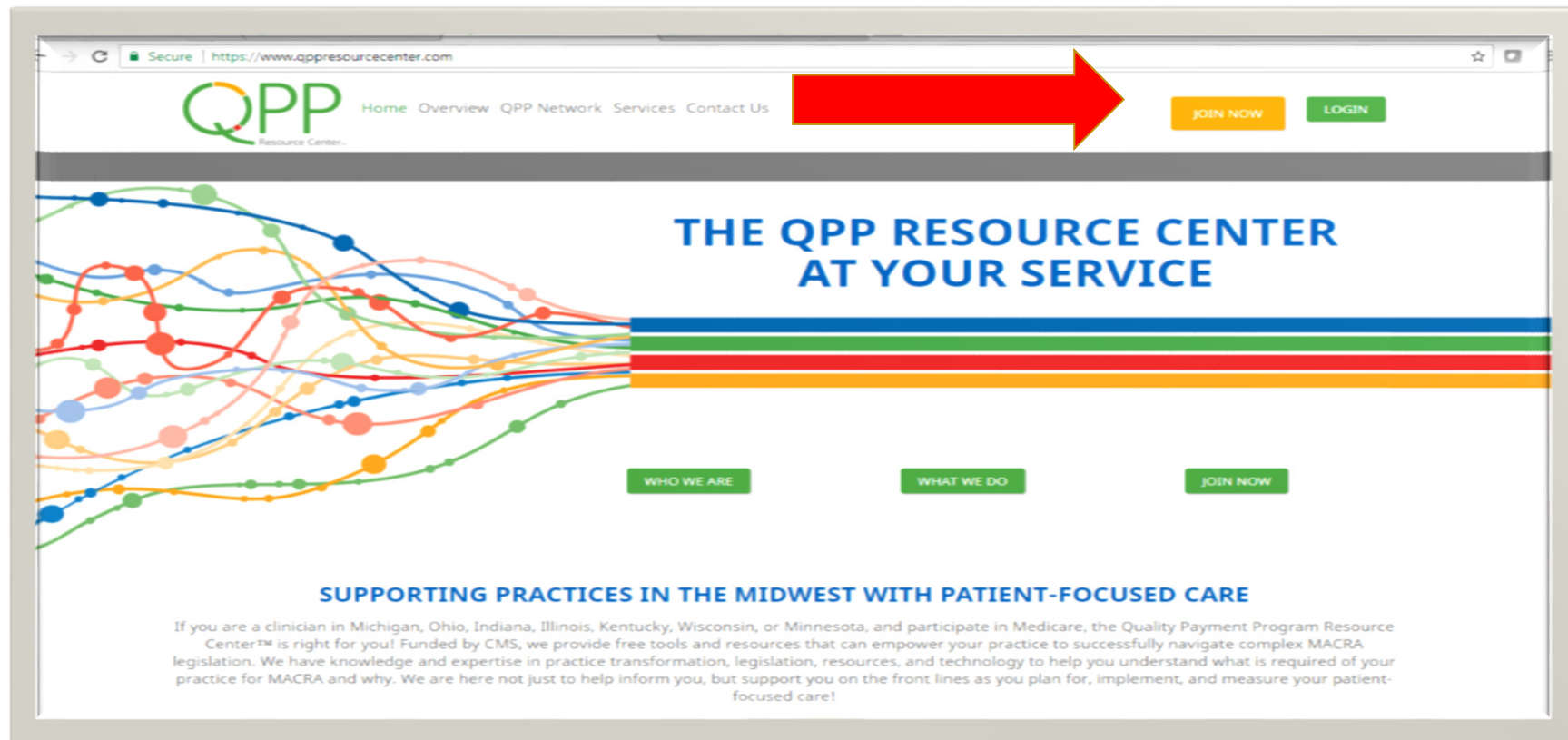
# Resources

- [MIPS 2019 Cost Performance Category Fact Sheet](#)
- [MIPS 2019 Summary of Cost Measures](#)
- Medicare Spending Per Beneficiary Measure Information Form
- Total Per Capita Cost Measure Information Form
- 2019 Cost Measure Information Forms (Episode Based zip files)
- 2019 Cost Measure Code Lists (Episode Based zip files)
- [2019 MIPS Opt-In and Voluntary Reporting Policy Fact Sheet](#)
- [Chronic Care Management Toolkit](#)
- [Annual Wellness Visit](#)
- [Transitional Care Management](#)

# Join QPP Resource Center-No Cost Assistance

**NO COST Support Available - Start by clicking JOIN NOW!**

<https://www.qppresourcecenter.com/>







# Questions?

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