Making "Cents" of the Quality Payment Program Cost Category

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Objectives of Webinar

- Reminder to check 2018 eligibility

- Learn why measuring cost is important for MIPS

- Learn the benefits of documenting your patients' medical conditions
  - *Risk Adjustment
  - *Coding

- Understand the value of the QRUR report and 2018 MIPS Feedback Report

Eligibility Status

- Verify participation status
  - https://qpp.cms.gov/participation-lookup

Eligibility Status (cont.)

Eligibility Dashboard Demo.mp4

- Enterprise Identity Management (EIDM) - Group
  - YouTube video

Why Focus on Cost?

- Measuring cost is an important part of MIPS because cost measures show:
    - The resources clinicians use to care for patients
    - Medicare payments made under the Physician Fee Schedule, Inpatient Prospective Payment System, etc. for items and services given to a patient during an episode of care
        - An episode of care is the basis for finding items and services from claims given in a specified timeframe

Cost Category Replaces Value Based Modifier

- The Cost category replaces the legacy Value-Based Modifier Program (VBM)

- 2016 was the last performance year for the VBM and this is the last year that Value Modifier payment adjustments will be applied due to implementation of the Quality Payment Program in 2017

- The VBM program included physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists, which are identical to MIPS eligible clinicians

Cost Category Replaces VBM (cont.)

- QRURs were provided for the VBM and PQRS legacy programs
- MIPS Feedback Report will replace QRUR for the participation year of 2017
  - Reports available summer of 2018

Cost Measures in 2018

- CMS will use two cost measures to measure performance in 2018:
  - Total Per Capita Cost measure
    - This measures all Medicare Part A and Part B costs during the MIPS performance period
  - Medicare Spending Per Beneficiary measure
    - This measure determines what services Medicare pays for that were performed by an individual clinician during the period immediately before, during, and after a patient's hospital stay (called an MSPB episode)

Total Per Capita Cost (TPCC) Measure

- The TPCC evaluates the overall cost of care provided to beneficiaries attributed to clinicians. It includes all Medicare Part A and Part B costs during the MIPS performance period for all attributed beneficiaries.

- This includes inpatient hospital, outpatient hospital, skilled nursing facility, home health, hospice, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and Part B claims

- Part D covered prescription drug costs are NOT included

TPCC Attribution of Patients

- For the TPCC measure, beneficiaries are assigned to a single Medicare Taxpayer Identification Number/National Provider Identifier (TIN-NPI) in a two-step process that considers:

  1. The level of primary care services they received (as measured by Medicare allowed charges during the performance period)

  2. The clinician specialties that performed these services

TCPP Attribution of Patients (cont.)

- Only beneficiaries who received a primary care service during the performance period are assigned to the TIN-NPI

- Primary care services include:
  - Evaluation and management services given in an office and other non-inpatient and non-emergency room settings
  - Initial Medicare visits
  - Annual wellness visits

- If you are a specialist caring for a patient, make sure your patients are seeing their primary care clinician

- If you are a primary care clinician, offering the Annual Wellness Visit is a way to manage cost

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Medicare Spending Per Beneficiary (MSPB)

- An MSPB episode includes all Medicare Part A and Part B claims during the episode
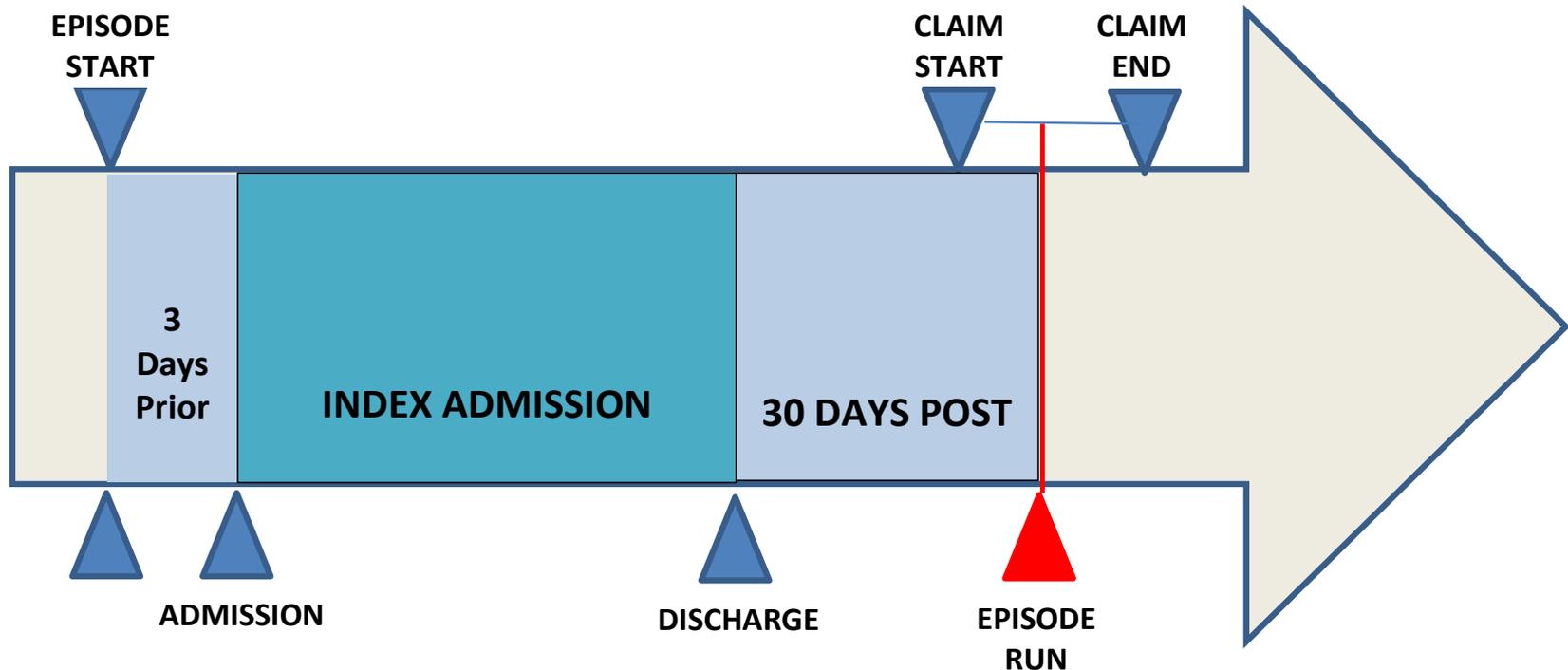
Cost Category Scoring

- Worth 10 percent of the total MIPS score in 2018
- Performance period is a full calendar year
  - Not primarily about what you charge for your services
  - No reporting required for this category
- CMS will calculate a score based on administrative claims:
  - If 2 measures can be scored$\rightarrow$ cost score is the average of the 2 measures
  - If only 1 measure can be scored $\rightarrow$ cost score is the score of that 1 measure
  - If neither measure can be scored$\rightarrow$ cost score is reweighted and quality category score increases to 60%
- Performance is compared against other MIPS eligible clinicians and groups during the same performance period; it is not compared to benchmarks from a previous year

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Identify Health of Patients

- **It is important to make Medicare aware of how sick or how healthy your patients are**

- It is crucial for primary care providers to be aware of when and where their patients access care

- For specialists, it is absolutely critical to ask every Medicare patient when they last saw their primary care provider

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Don't Let Your Patients "Fall Off"

- Report each mapping condition (recurring illness) **at least once in the calendar year**

- A "clean slate" begins every January 1st

- Every chronic, non-resolving diagnosis needs to be reported at least once on a claim denoting a face-to-face visit with an acceptable type of provider, in an acceptable setting

- If this is not reported, the condition is considered to "fall off"

Building Risk Scores

- Evaluate the health of your patients and build "risk scores" based on medical coding
  - The sicker the person, the higher the risk score, and consequently, the higher the payment

Goal of Risk Adjustment

- The goal of risk adjustment is to enable more accurate comparisons across Medicare Taxpayer Identification Numbers (TINs) that treat beneficiaries of varying clinical complexity by:
    - Removing differences in health
    - Removing other risk factors that impact outcomes but are not under the TIN's control

Hierarchical Coding Category (HCC)

- Cost measures are risk-adjusted to account for differences in patient characteristics, such as having multiple chronic conditions that may affect a clinician's performance on the measure

- Risk adjustment is based on hierarchal condition category (HCC) risk scores

Coding Reminders

- Chronic Disease Burden
- ICD-10-CM diagnoses: think "complete, accurate & consistent"
- Disease Hierarchies: think "severity" and/or "specificity"
- Disease Interactions: think "complexity and completeness"

Performance Feedback

- Prior to 2017, cost measure feedback was available on the Quality and Resource Use Report (QRUR) from the VBM program

- In July 2018, CMS will provide cost measure feedback based on the 2017 MIPS performance year with a new report called the MIPS Feedback Report

- The MIPS Feedback Report replaces the QRUR

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Performance Feedback (continued)

- CMS will provide feedback for 2017 even though the Cost performance category does not affect 2017 MIPS payments

- The QRUR will no longer be distributed because the VBM program ended in 2016
  - Clinicians should review 2016 QRUR reports now as they are closely related to the new MIPS Feedback Report
  - This review will give your Medicare Spending per Beneficiary (MSPB) and total per capita cost (TPCC) scores

Improving Cost Category Score

- Does your practice have control on how patients spend their Medicare dollars?

- You can gain control if you follow these suggestions:
  - Properly code claims
  - Avoid duplication of tests
  - Educate patients on what situations require an emergency room visit, medical aid unit visit, or contacting their physician after hours
  - Contact your Quality Insights representative or Help Desk for one-on-one assistance in identifying methods based on your practice type

Resources

- Check Eligibility Status
  - https://qpp.cms.gov/participation-lookup
- EIDM Account
  - https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-EIDM-User-Guide.pdf
- AWV Toolkit
  - https://www.qualityinsights-qin.org/Initiatives/Annual-Wellness-Visit/SIP2-Annual-Wellness-Visit-Change-Package.aspx
- CMS Cost Fact Sheet
  - https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Cost-Performance-Category-Fact-Sheet.pdf
- QPP Year 2 – Final Rule
  - https://www.cms.gov/Medicare/Quality-Payment-Program/resource-library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf

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Questions

Contact Us

- **Quality Insights QPP Support Center**
  - For practices with **15 or fewer** eligible providers
  - Email: qpp-surs@qualityinsights.org
  - Phone: 877.497.5065
  - Website: www.qppsupport.org

- **Quality Insights Quality Innovation Network (QIN)**
  - For practices with **16 or more** eligible providers
  - Email: kwild@qualityinsights.org
  - Phone: 877.987.4687, Ext. 108
  - Website: www.qualityinsights-qin.org

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