Quality Payment
PROGRAM

# Merit-based Incentive Payment System(MIPS): Episode-Based Cost Measure Field Test Reports Fact Sheet

## What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established the Quality Payment Program, a new way to pay clinicians.

Under the Quality Payment Program, clinicians are rewarded for giving high-quality and high value care through Advanced Alternate Payment Models (APMs) or the Merit-based Incentive Payment System (MIPS). Clinicians participating in MIPS will earn a performance-based payment adjustment to their Medicare payment. This payment adjustment is based on a MIPS final score that assesses evidence-based and practice-specific quality data in the following categories:

1. Quality
2. Improvement activities
3. Advancing care information
4. Cost

The MIPS cost performance category will be calculated in 2017, but will not be used to determine payment adjustment. That is, the cost performance category of the MIPS final score is weighted at zero percent for the 2017 performance year; it also is proposed to continue to be weighted at zero percent of the MIPS final score for the 2018 performance year.

As required by MACRA, the MIPS cost performance category will be weighted at 30 percent of the MIPS final score for the 2019 performance year meaning that it will affect payment in the 2021 payment year.

## How do episode-based cost measures relate to the Quality Payment Program?

MACRA established a process to enhance the infrastructure for resource use measurement, including for the purpose of developing cost measures for the MIPS cost performance category. MACRA requires cost measures implemented in MIPS to include consideration of patient condition groups and care episode groups (referred to as “episode groups”). As a result, eight episode-based cost measures are currently under development and are being field tested.

These 8 measures are being developed with extensive input from 7 Clinical Subcommittees (CS), a Technical Expert Panel, and public comment:

- Elective Outpatient Percutaneous Coronary Intervention (PCI)
- Knee Arthroplasty
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia
- Routine Cataract Removal with Intraocular Lens (IOL) Implantation

- Screening/Surveillance Colonoscopy
- Intracranial Hemorrhage or Cerebral Infarction
- Simple Pneumonia with Hospitalization
- ST-Elevation Myocardial Infarction (STEMI) with PCI

## When will these episode-based measures be used in MIPS?

The eight episode-based measures currently being field tested and are **not** included in the 2017 or 2018 MIPS performance years. These measures are being field tested before consideration of their potential use in the MIPS cost performance category in a future year. As part of this field testing, CMS and Acumen are now seeking stakeholder feedback on the draft measure specifications for the eight measures in their current stage of development, the Field Test Report template, and all accompanying documentation. This feedback will be considered in refining the measures and for future measure development activities.

CMS will consider stakeholder feedback, public comments, measure refinements, and Measure Applications Partnership recommendations before considering the potential use of these eight episode-based cost measures in the MIPS cost performance category for future years. This would involve proposing the measures for use in MIPS as part of the notice-and-comment rulemaking process.

## How do these cost measures relate to other measures in the MIPS cost performance category?

These episode-based cost measures are currently under development and have not yet been proposed for use in the Quality Payment Program. They are being reported to clinicians currently as a part of field testing to gather stakeholder feedback on the measures to inform refinements before consideration of their potential use in the Quality Payment Program.

Two other cost measures, the Medicare Spending Per Beneficiary (MSPB) measure for clinicians and the Total Per Capita Cost (TPCC) measure, have been finalized for use in the 2017 MIPS performance period and proposed for continued inclusion in the 2018 performance period through the CY 2018 Quality Payment Program Proposed Rule. However, as mentioned above, the weighting of the cost performance category will be zero percent in 2017 and has also been proposed to remain at zero percent for the 2018 performance period.

The MSPB and TPCC measures have been reported to clinicians previously through the Quality and Resource Use Reports (QRURs), including reports on those measures that were released on September 18, 2017. The field testing of the new episode-based cost measures is separate from these measures reported in the QRURs. Clinicians who do not receive field testing reports for any of the 8 episode-based cost measures under development may receive QRURs containing their MSPB or TPCC cost measure performance.

## Why are these episode-based cost measures being field tested now?

Through field testing, CMS and Acumen are looking for voluntary feedback on 8 episode-based cost measures and the measure reporting format. We will use this feedback to determine whether these measures should be considered for potential use in the Quality Payment Program, and how the measures and reporting format should be improved to provide clinicians actionable information to ensure high quality and high value care. Field testing also serves as an opportunity for clinicians to learn about and gain experience with episode-based cost measures before they are included in MIPS.

Specifically, we are looking for feedback on the following types of questions:

- Does the information presented on the measure in the field test report and accompanying documentation help you identify actionable improvements to patient care and to cost efficiency?
- Are the measure specifications for the 8 episode-based cost measures clinically valid? Measure specifications include episode triggers, attribution, assigned services, episode windows, and risk adjustment.
- How can the information be presented in such a way that it is most useful for quality improvement?
- How understandable is the measure documentation provided, and what portions of the documentation could be clearer or more detailed?
- Would any additional documents or information be useful to help clinicians and other stakeholders understand these measures?

## How does field testing work?

Field testing is a voluntary opportunity for affected clinicians and other stakeholders to provide feedback on the measure specifications and the report template. We will be testing the 8 measures in their current stage of development to get clinician and stakeholder feedback on the draft measure specifications and report template by:

- Posting confidential clinician feedback reports for certain group practices and solo practitioners on the CMS Enterprise Portal. See further detail on who is likely to receive a Field Test Report in the next question and answer.
- Posting a mock report, draft measure specifications, and related documentation on the CMS MACRA page.

## Who will receive a Field Test Report?

Clinicians likely to get a report on the CMS Enterprise Portal are those who:

- perform the procedures (for procedural episode groups) or manage hospitalizations for conditions (for acute inpatient medical conditions episode groups) for one or more of the 8 measures above are likely to get a report.
- are attributed 10 or more episodes during the measurement period (June 1, 2016 to May 31, 2017) to get a report.

Field Test Reports are available at the clinician group practice and solo practitioner level. For clinician group practices, the group practice must be attributed at least 10 or more episodes across all clinicians billing the group practice. For solo practitioners, the clinician must be attributed at least 10 or more episodes. Please see the next question and answer for more details about how to access the reports.

Clinicians who do not meet the criteria listed above will not receive a report. We encourage clinicians who don't receive a report and all other stakeholders to review and comment on the mock report, draft measure specifications, and related documentation.

## How can clinicians access their Field Test Report?

Clinicians or clinician group's authorized representatives can access the Cost Measure Field Test Report(s) at https://portal.cms.gov using an Enterprise Identity Management (EIDM) account with one of the following roles in the **Physician Quality and Value Programs** application:

- Groups are identified in the EIDM by their Medicare billing Taxpayer Identification Number (TIN). A group consists of **two or more eligible clinicians** (as identified by their National Provider Identifier [NPI] that bill under the same TIN), and will receive a report if the TIN is attributed at least 10 or more episodes among all NPIs billing under the TIN. A group can have either of the following roles:
  - Security Official
  - Group Representative

  The group-level users (i.e., Security Official and Group Representative) have access to the group practice's reports and the individual-level reports for the solo practitioners within the group practice.
- An individual eligible clinician (or a solo practitioner) is identified by a single NPI that bills under the TIN, and will receive a report if the NPI is attributed at least 10 or more episodes. A solo practitioner can have either of the following roles:
  - Individual Practitioner
  - Individual Practitioner Representative

Clinicians can get ready to access their reports by signing up for a new EIDM account using this EIDM user guide, or by making sure existing EIDM accounts have the 'Physician Quality and Value Programs' role using this existing EIDM user guide.

## When is field testing for these episode-based cost measures?

Field testing starts on Monday, October 16, 2017 and ends on November 15, 2017. During this period, stakeholders may submit feedback on the measures through the process outlined in the next question and answer.

## How can I give feedback on episode-based cost measures?

All stakeholders can send us feedback on the measures, documentation, and report presentation through this online survey between October 16 and November 15, 2017. Comments may be submitted through this online survey, and stakeholders can attach a PDF or Word document with their comments. Comments may be submitted anonymously if preferred. If you have questions or want more information, please send us an email at QPPCostMeasureTesting@ketchum.com.

## What are episode-based cost measures?

Episode-based cost measures represent the cost to Medicare for the items and services furnished to patients during an episode of care ("episode"). Episode-based cost measures are developed to inform clinicians on the cost of care for an episode during which they manage the care for an acute medical condition or perform a procedure. In the Field Test Reports and accompanying documentation, the term "cost" means the amount Medicare pays on traditional, fee-for-service claims.[1]

Episode-based cost measures are calculated with Medicare Parts A and B fee-for-service claims data and are based on episode groups. Episode groups:

- Represent a clinically cohesive set of medical services rendered to treat a given medical condition.
- Aggregate all items and services provided for a defined patient cohort to assess the total cost of care.
- Are defined around treatment for a condition (i.e., acute inpatient or chronic) or performance of a procedure.

## How are episodes attributed to a clinician?

After episodes are opened, or triggered, based on the occurrence of a trigger event, we determine attributed clinicians using information from the trigger claims.

- The attributed clinician is identified by a unique Taxpayer Identification Number/National Provider Identifier (TIN-NPI) informed by the performing NPI field on the Physician/Supplier Part B (Carrier) claim.
- For procedural episode groups, episodes are attributed to the clinician(s) rendering the trigger services (HCPCS/CPT procedure codes).
  - For example, an orthopedic surgeon billing HCPCS/CPT code 27446 would be attributed a Knee Arthroplasty episode.
- For acute inpatient medical condition episode groups, episodes are attributed to the clinician(s) rendering least 30 percent of inpatient evaluation and management (E&M) services during an inpatient hospitalization with a Medicare Severity Diagnosis-Related Group (MS-DRG) for the episode group.

[1] Specifically, cost is defined by allowed amounts on Medicare claims data, which include both Medicare trust fund payments and beneficiary deductible and coinsurance.

- For example, a neurologist billing 30 percent of inpatient E&M codes on Part B Physician/Supplier claims concurrent to an inpatient hospitalization with MS-DRG code 065 would be attributed an Intracranial Hemorrhage or Cerebral Infarction episode.

## How are episode-based cost measures calculated?

To calculate the measures, we perform the following steps using all episodes in an episode group that are attributed to a clinician or clinician group:

- Determine observed costs for each episode by aggregating Part A and Part B standardized allowed amounts for services related to a given condition or procedure that occur within the episode window.
- Determine expected costs for each episode through risk adjustment by taking into account factors that are included in the CMS Hierarchical Condition Category Version 22 (CMS-HCC V22) as well as additional risk adjustors that were recommended by Clinical Subcommittees for each episode group.
- Sum the ratio of observed to expected payment-standardized cost to Medicare for all episodes attributed to a provider and divide that sum by the total number of episodes attributed to the provider. This is then multiplied by the national average observed episode cost to generate the risk-adjusted average episode costs, which represents the cost measure score.

## How are episode-based cost measures developed?

The process of developing these measures has involved a series of steps required by MACRA whereby comments have been solicited from stakeholders on episode groups and trigger codes. We have worked with a measure development contractor (Acumen, LLC) to develop episode-based cost measures, and we asked for public feedback on them.

## Where can I get more information about episode-based cost measures?

If you have questions, email QPPCostMeasureTesting@ketchum.com.