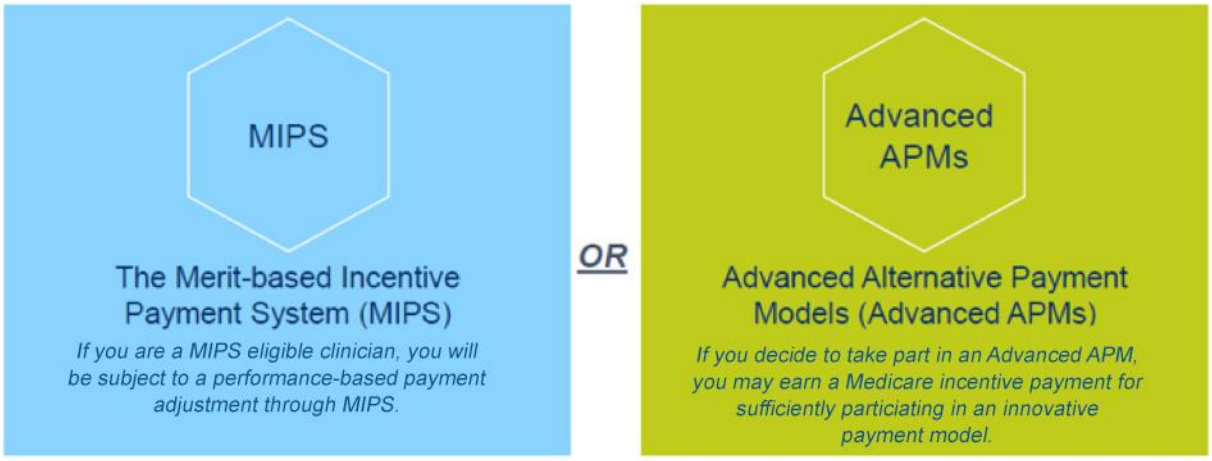
Quality Payment
PROGRAM

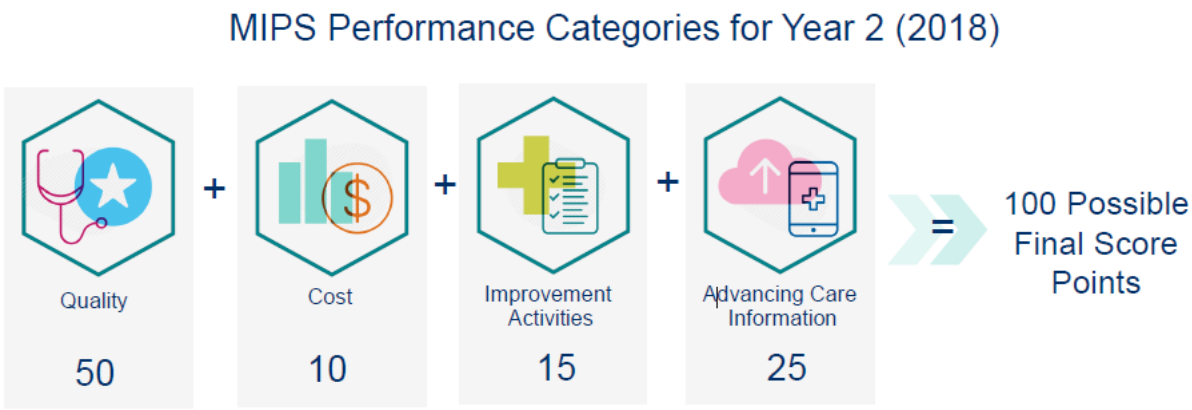
2018 Merit-based Incentive Payment System (MIPS) Cost Performance Category Fact Sheet

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have made major cuts to payment rates for clinicians participating in Medicare. The law requires us to implement the Quality Payment Program and gives clinicians 2 ways to participate:



Under MIPS, there are 4 performance categories that affect your future Medicare payments. Each performance category is scored by itself and has a specific weight that's its part of the MIPS Final Score. The payment adjustment assessed for MIPS eligible clinicians is based on the Final Score. These are the performance category weights for the 2018 performance period:



This fact sheet focuses on the MIPS Cost performance category, which uses parts of the Value Modifier program, which is one of the legacy programs to sunset under MACRA.

Why Focus on Cost?

Measuring cost is an important part of MIPS because cost measures show:

- The resources clinicians use to care for patients.
- The Medicare payments (for example, payments under the Physician Fee Schedule, IPPS, etc.) for care (items and services) given to a beneficiary during an episode of care. An episode of care is the basis for finding items and services from claims given in a specified timeframe.

What are Cost Measures?

For 2018, MIPS uses cost measures that cover the total cost of care during the year or during a hospital stay. We plan to use episode-based measures in the future.

The Cost performance category uses your Medicare claims data to collect Medicare payment information for the care you gave to beneficiaries during a specific period of time. Because we use Medicare claims data, we'll calculate the Cost performance category score and **you don't have to submit any data**.

For the 2017 transition year, the Cost performance category didn't count toward your total MIPS score. In year 2, it does count for 10% of your total MIPS score.

Transition year (2017)	Year 2 (2018)
We used a 0% weight for the Cost performance category when we calculated your MIPS final score for the transition year (2017 MIPS performance period). The cost category was given a 0% weight in the 2017 calculations to give you the chance to understand the attribution and scoring methods.	We finalized a weight of 10% for the 2018 MIPS performance period to help you get ready for a higher weighting in the future. The 10% cost weight will help you: • Have an easier transition to the 30% cost weight MACRA requires starting with the 2019 MIPS performance period. • Urge you to review and understand your performance on cost measures.

If you participate in a MIPS APM, the MIPS APM will apply a 0% weight to the Cost performance category because many MIPS APMs measure cost in other ways.

How are Cost Measures Calculated?

Our goal is for cost measures to go with the quality of care assessment so that we can work toward better patient outcomes and smarter spending at the same time. Events such as hospitalizations, readmissions, and certain complications can be identified through claims analysis and can inform on the quality of care furnished during an episode. Because these events can be captured using claims analysis, no additional data submission is required.

Cost measures are risk adjusted to account for differences in beneficiary-level risk factors that can affect quality outcomes or medical costs, regardless of the care provided. The goal of risk adjustment is to enable more accurate comparisons across Medicare Taxpayer Identification Number (TINs) that treat beneficiaries of varying clinical complexity, by removing differences in health and other risk factors that impact measured outcomes but are not under the TIN's control.

What are the Year 2 Cost Measures?

In year 2, we will only use two cost measures to measure performance:

- Total Per Capita Cost measure
- Medicare Spending Per Beneficiary measure

Total Per Capita Cost (TPCC) Measure

The TPCC measure measures of all Medicare Part A and Part B costs during the MIPS performance period.

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:

- The level of primary care services they received (as measured by Medicare allowed charges during the performance period).
- The clinician specialties that performed these services.

Only beneficiaries who received a primary care service during the performance period are assigned to the TIN-NPI. Here are the two-steps used to assign beneficiaries to a TIN-NPI for the TPCC measure:

1. If a beneficiary received more primary care services (PCS) from primary care physicians (PCPs), nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs) in that TIN-NPI than in any other TIN-NPI or CMS Certification Number (CCN), the beneficiary is assigned to the TIN-NPI in the first step.

   - If the beneficiary received more PCS from PCPs, NPs, PAs and CNSs from a CCN than any other TIN-NPI, this beneficiary:
     - Would be assigned to the CCN.
     - Wouldn't be assigned to any TIN-NPIs.
     - Would be excluded from risk adjustment.

     If two TIN-NPIs tie for the largest share of a beneficiary's primary care services, the beneficiary will be assigned to the TIN-NPI that last gave primary care services.

Primary care services include:

- Evaluation and management services given in office and other non-inpatient and non–emergency-room settings
- Initial Medicare visits and annual wellness visits.

2. If the beneficiary did not receive primary care service from any PCP, NP, PA, or CNS during the performance period and received more primary care services from non-primary care physicians within the TIN-NPI than in any other TIN-NPI or CCN, the beneficiary is assigned to a TIN-NPI in the second step.

Please note that if two TIN-NPIs tie for the largest share of a beneficiary's primary care services, the beneficiary will be attributed to the non-primary care TIN-NPI that provided primary care services most recently. If the beneficiary received more PCS from non-primary care physicians from a CCN than any TIN-NPI, this beneficiary would be attributed to the CCN, would not be attributed to any TIN-NPIs, and would be excluded from risk adjustment. If the beneficiary did not receive any primary care service via PCP, NP, PA, CNS or non-primary care physician, then the beneficiary wouldn't be attributed.

Medicare Spending Per Beneficiary (MSPB) Measure

The MSPB clinician measure determines what Medicare pays for services performed by an individual clinician during an MSPB episode: the period immediately before, during, and after a patient's hospital stay.

An MSPB episode includes all Medicare Part A and Part B claims during the episode, specifically claims with a start date between three days before a hospital admission (the "index admission" for the episode) through 30 days after hospital discharge.

The MSPB measure is assigned to individual clinicians, as identified by their unique TIN-NPI. MSPB measure performance may be reported at either the clinician (TIN-NPI) or the clinician group (TIN) level.

How Will I Get Performance Feedback?

You may have already been getting feedback for several years on cost measures from the Value Modifier program reports and the Physician Feedback Program, Quality and Resource Use Reports (QRURs). In 2018, we'll give you feedback on cost measures used in the 2017 MIPS transition year. Although the Cost performance category doesn't affect your payments for the transition year, we'll still give you performance feedback to help you get familiar with cost measures.

How Will I Be Scored?

We'll calculate your or your group's Cost performance if the case minimum of attributed beneficiaries (i.e., 20 cases for total per capita cost measure, or 35 cases for MSPB measure) is met. If the case minimums aren't met for either of the 2 measures, we'll reweight the Cost performance category weight to the Quality performance category. This will make the Quality performance category worth 60% of your 2018 MIPS total score.

To figure your Cost performance category score, we'll

- Assign 1 to 10 points to each measure.
- Compare your performance to other MIPS-eligible clinicians' and groups' during the performance period, not on a past year.

$$\text{COST PERFORMANCE} = \frac{\text{Total Points Scored on Each Measure}}{\text{Total Possible Points Available}}$$

The Cost performance category score is the average of the 2 measures, but If only 1 measure can be scored, that score will be the performance category score.

Measure	Measure achievement points earned by the group	Total Possible Measure Achievement Points
TPCC measure	8.2	10
MSPB measure	6.4	10
TOTAL	**14.6**	**20**

This group's Cost performance category is (14.6/20) which is equal to a cost performance category percentage score of 73%. Because the cost performance category is worth 10 points in the final score, this group would earn 7.3 points towards their final score.

What are Episode-based Cost Measures?

Episode-based measures focus only on services related to the clinical condition or procedure being measured. These measures are different than the TPCC and MSPB measures that include all services provided to a patient over a specific period.

In October 2017, we field tested 8 episode-based Cost measures to get stakeholder feedback on:

- The draft measure specifications for the 8 measures in their current stage of development.
- The Field Test Report template.
- All accompanying documentation.

We'll use this feedback to refine the measures and to develop future measures.

We were field testing these measures before we thought to use them in the MIPS Cost performance category.

How are episode-based Cost Measures Built?

There are 5 key parts to building episode-based Cost measures:

1. Defining an episode group
2. Assigning costs to the episode group
3. Attributing the episode group to one or more responsible clinicians
4. Risk adjusting episode group resources or defining episodes to compare beneficiaries that are alike
5. Aligning as much as possible, episode groups with quality indicators

Before Cost measures can be fully developed, episode groups should be built and clarified in the context of the quality of clinician care.

We'll consider stakeholder feedback, public comments, measure refinements, and Measure Applications Partnership recommendations before we decide how to use these 8 episode-based cost measures in the MIPS cost performance category in the future. The notice-and-comment rulemaking process will be used to decide if the measures will be used in MIPS. We'll do more field testing in spring and fall 2018.

How Do I Get Help or More Information?

You can reach the Quality Payment Program at 1-866-288-8292 (TTY 1-877-715-6222), Monday through Friday, 8:00 AM-8:00 PM ET or by email at: QPP@cms.hhs.gov.

Where Can I Find Resources?

2018 MIPS Cost Measures
CY 2017 Quality Payment Program Final Rule
CY 2018 Quality Payment Program Final Rule with comment
The Quality Payment Program Resource Library
2017 Episode-based Cost Measures Field Testing