Merit-Based Incentive Payment Program (MIPs): Cost Category

Radiology Deep Dive

July 13th, 2023

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Agenda

- **Quick Program Recap**
- **Unpacking the Cost Category**
  - Medicare Spending Per Beneficiary
  - Total Per Capita Cost
  - Episode Based Measures
- **Reviewing Cost Feedback**
- **What can you do if you are scored on Cost?**
- **Submitted Questions**

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Quick Program Recap

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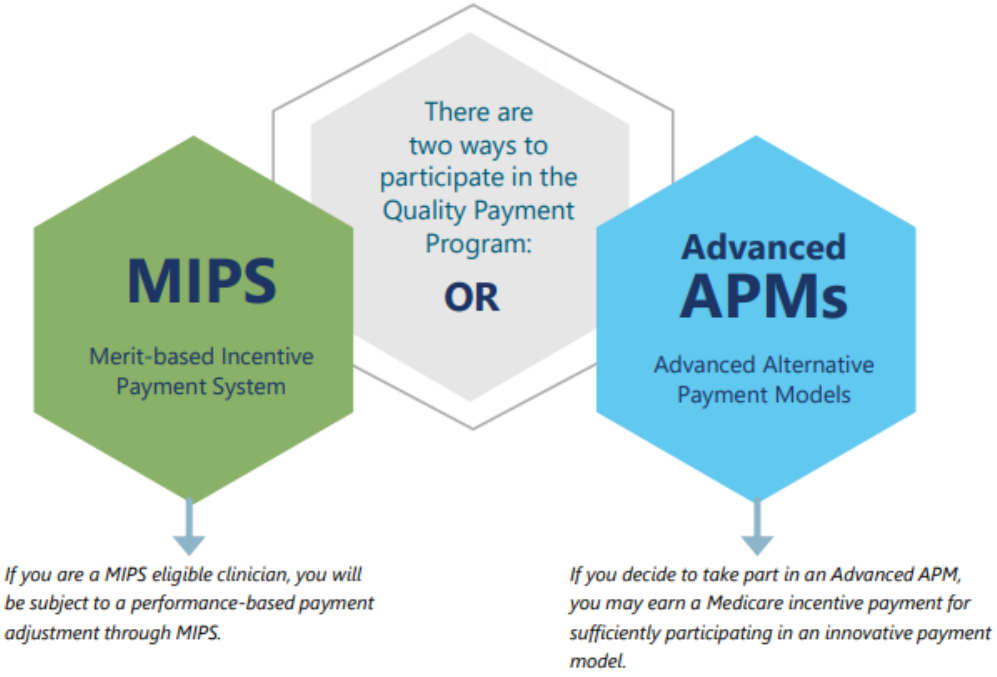
Quick MIPS Recap

The Quality Payment Program was established by the Medicare Access and CHIP Reauthorization Act of **2015** (MACRA) with the intent to reward clinicians for providing high-quality, low-cost care to Medicare beneficiaries.



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Quick MIPS Recap

The QPP program established **MIPS** as the replacement for **PQRS** as Medicare's primary quality reporting program in **2017**.

MIPS is a **budget neutral program** that offers participants the opportunity to earn a payment adjustment based on a total program score comprised of four performance categories:

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Quick MIPS Recap

Clinicians enrolled in **Medicare** for *at least* **1 year** who meet **all** elements of the QPP's **low volume threshold** ***as an individual*** must participate in MIPS

- **Low Volume Threshold (LVT):**
  - **$90,000 in Medicare Part B**
  - **200+ Medicare Part B Services**
  - **200+ Medicare Part B Beneficiaries**

Interactions with ***Alternative Payment Models*** *shift QPP eligibility and reporting responsibilities*

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Quick MIPS Recap

Performance Thresholds and Category Weights

Performance	2023
Penalty	**75**
Exceptional Performer*	**N/A**
Maximum Payment Adjustment	**+/- 9%**
Category Weights	
Quality	30%
Cost	30%
Promoting Interoperability	25%
Improvement Activities	15%

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Quick MIPS Recap

Special Statuses granted under the program change how providers participate

Common for Radiology/Anesthesia/Pathology:

- **Non-Patient Facing**: qualifies for 2x the points for each improvement activity submitted, *automatic reweighting of the Promoting Interoperability category* to 0% - category weight shifts to Quality

- **Hospital-Based:** qualifies for *automatic reweighting of the Promoting Interoperability performance category* to 0% - category weight shifts to Quality

- **Facility-Based:** qualifies for Facility-based scoring of the Quality and Cost categories by association with a hospital in the HBVP program

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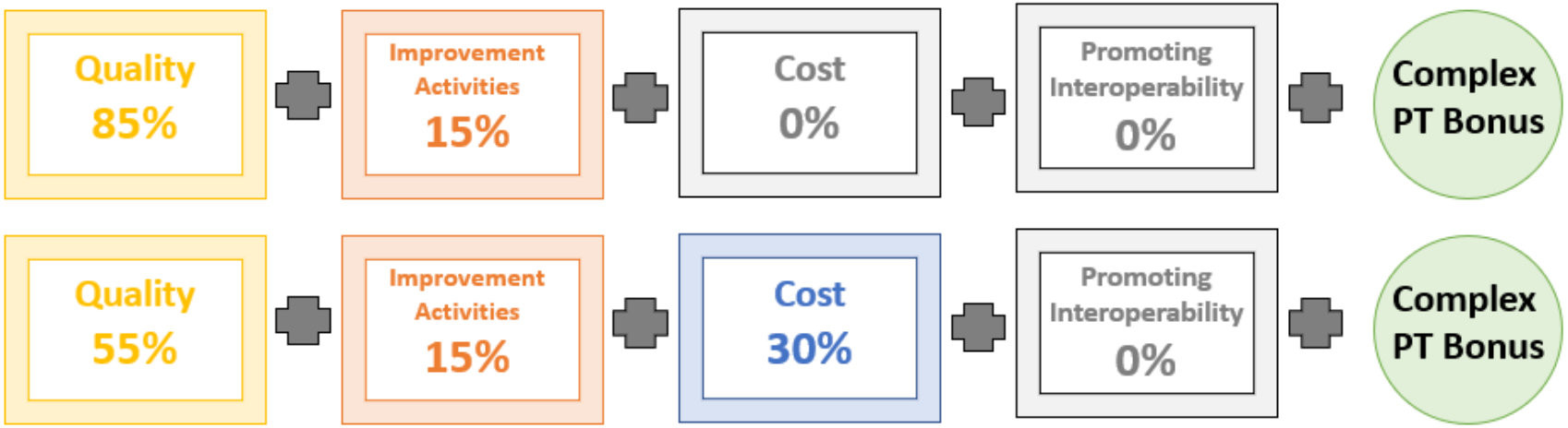
Quick MIPS Recap

Final Score Scenarios: *LARGE* Practices



Small Practices (15 or fewer providers) qualify for:

Quality – 50%

Improvement Activities – 50%

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Unpacking the Cost Category

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Cost Category

- **Data submitted from Medicare claims during the performance year, no extra effort needed to submit anything to CMS**
  - *CMS automatically calculates category for you*

- **Unlike the QUALITY category, participants do not select which measures to report**
  - *CMS calculates the measures that apply and scores your performance*
  - *Category score adjusted based on what applies*

- **Cost measure scores are based on performance year data**
  - *No way to know how you will score against category until data is released*
  - *Extremely difficult to control outcome*

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Cost Category

The Cost Category looks at cost of beneficiary care using various ‘measures’:

Measure Name/Type	Description	Case Minimum	Data Source
★ **Total Per Capita Cost (TPCC)**	This population-based measure assesses the overall cost of care delivered to a Medicare patient with a focus on primary care received.	20 Medicare patients	Medicare Parts A and B claims data
★ **Medicare Spending Per Beneficiary Clinician (MSPB Clinician)**	This measure assesses the cost of care for services related to qualifying inpatient hospital stays (immediately prior to, during, and after) for a Medicare patient.	35 episodes	Medicare Parts A and B claims data
15 procedural episode-based measures	Assess the cost of care that’s clinically related to a specific procedure provided during an episode’s timeframe.	10 episodes for all procedural episode-based measures **except** the Colon and Rectal Resection measure which has a case minimum of 20 episodes	Medicare Parts A and B claims data
6 acute inpatient medical condition episode-based measures	Assess the cost of care clinically related to specific acute inpatient medical conditions and provided during an episode’s timeframe.	20 episodes for acute inpatient condition episode-based measures	Medicare Parts A and B claims data (all acute inpatient condition episode-based cost measures), Medicare Part D claims (Sepsis episode-based cost measure)
2 chronic condition episode-based measures	Assess the cost of care clinically related to the care and management of patients’ specific chronic conditions provided during a total attribution window divided into episodes.	20 episodes for chronic condition episode-based measures	Medicare Parts A, B and D claims data

Cost Category - MSPB

Medicare Spending Per Beneficiary – *looks at total costs of* ***INPATIENT episodes*** *for Medicare patients*

MSPB episodes are classified as either **medical** or **surgical**, based on the Medicare Severity-Diagnosis Related Group (MSDRG) of the index admission.

- A **medical** MSPB Clinician episode is:
  - First attributed to a TIN if that TIN billed ***at least 30% of the E&M services*** on Part B physician/supplier claims during the inpatient stay.
  - Then attributed to any clinician in the TIN who billed at least one inpatient E&M service that was used to determine the episode's attribution to the TIN.

- A **surgical** MSPB Clinician episode is attributed to the clinician(s) who performed **any related surgical procedure during the inpatient stay** as well as to the TIN under which the clinician(s) billed for the procedure.

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Cost Category - MSPB

Specialties unlikely to qualify for 'medical' episode attribution, but could trigger 'surgical' attribution depending on services performed

Examples **of types of radiological procedures applicable to measure:**

- **Breast biopsy w/ localization device placement**
- **Vein/Artery/Biliary Drainage catheter placements**
- **Tunneled port placements/removals**
- **Tumor/bone ablations**
- **Stent placements**
- **G-tube placements/removals**
- **Radiation therapy planning**

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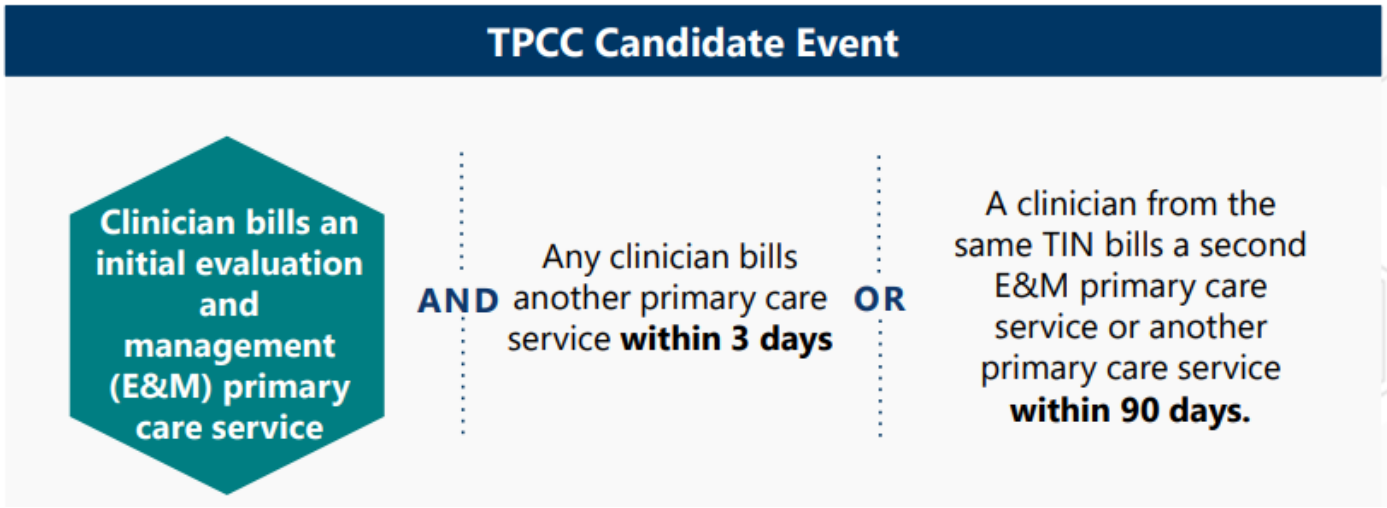
Cost Category - TPCC

Total Per Capita Cost – *looks at costs associated with* ***PRIMARY CARE*** *during the performance year*

TPCC Measure Attribution*

TPCC attribution begins with a "candidate event," defined as a pair of services billed by the clinician to the patient within a short period of time. A candidate event marks the start of a primary care relationship between a patient and a clinician.



Specialty **provider <u>types</u> not eligible to bill the initial E&M service….but…**
….NPs/PAs are….

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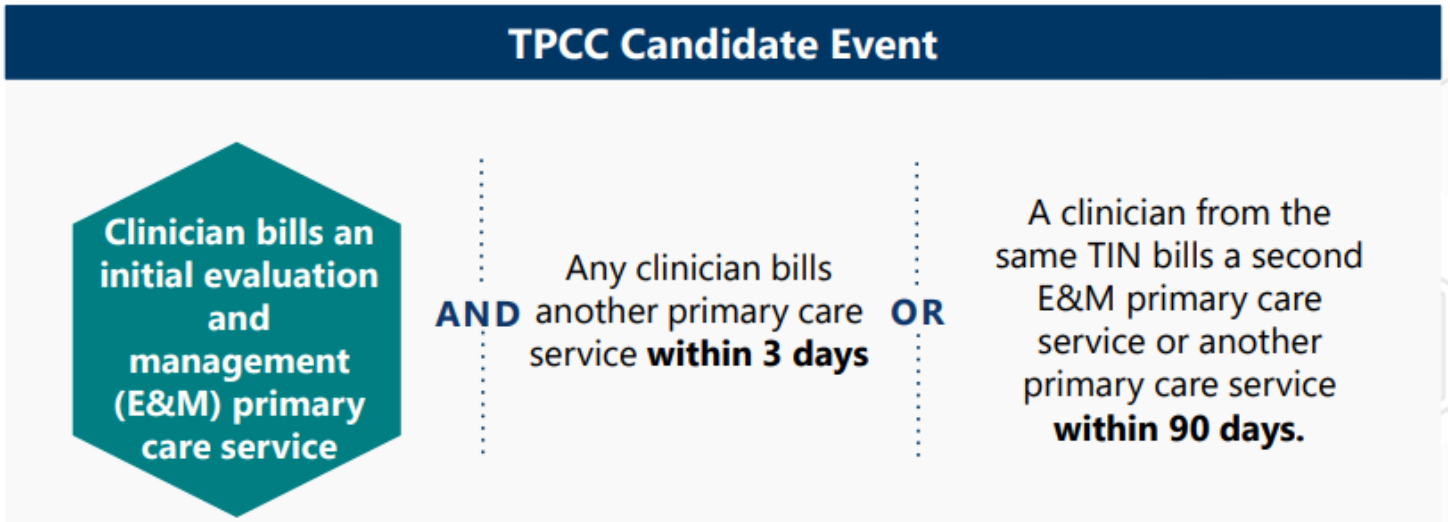
Cost Category - TPCC



E&M Primary Care Service	Primary Care Service include:
99202-99215 – New/Established patient visit in outpatient settings **993XX-994XX** – Patient visits in settings such as patient home, chronic care management settings, nursing homes, etc	• **X-rays** • **Mammograms** • **Higher level established patient visits** • **Office consultations**

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Cost Category – Episode Measures

Episode Based Cost Measure Name	Trigger Claims	Trigger Settings
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	Medicare Parts A, B and D	The most frequent settings in which an Asthma/COPD episode is triggered include: Office, SNF, and OP Hospital.
Diabetes	Medicare Parts A, B and D	The most frequent settings in which an Asthma/COPD episode is triggered include: Office, SNF, and OP Hospital.
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Medicare Parts A and B	Acute IP hospitals.
Intracranial Hemorrhage or Cerebral Infarction	Medicare Parts A and B	Acute IP hospitals.
Lower Gastrointestinal Hemorrhage (groups only)	Medicare Parts A and B	Acute IP hospitals.
Sepsis	Medicare Parts A, B and D	Acute IP hospitals.
Simple Pneumonia with Hospitalization	Medicare Parts A and B	Acute IP hospitals.
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Medicare Parts A and B	Acute IP hospitals.
Acute Kidney Injury Requiring New Inpatient Dialysis	Medicare Parts A and B	Acute IP hospitals
Colon and Rectal Resection	Medicare Parts A and B	ASCs, HOPDs, and acute IP hospitals.
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Medicare Parts A and B	Ambulatory/office-based care centers, outpatient hospitals, Ambulatory surgical centers (ASCs)
Elective Primary Hip Arthroplasty	Medicare Parts A and B	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Femoral or Inguinal Hernia Repair	Medicare Parts A and B	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Hemodialysis Access Creation	Medicare Parts A and B	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Knee Arthroplasty	Medicare Parts A and B	Acute inpatient (IP) hospitals, hospital outpatient department (HOPDs), ambulatory/office-based care centers, and ASCs
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Medicare Parts A and B	ASCs, HOPDs, and acute IP hospitals
Lumpectomy, Partial Mastectomy, Simple Mastectomy	Medicare Parts A and B	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Melanoma Resection	Medicare Parts A and B	ASCs, ambulatory/officebased care, and HOPDs.
Non-Emergent Coronary Artery Bypass Graft (CABG)	Medicare Parts A and B	Acute IP hospitals
Renal or Ureteral Stone Surgical Treatment	Medicare Parts A and B	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Medicare Parts A and B	ASCs, HOPDs, and acute IP hospitals
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Medicare Parts A and B	ASCs and HOPDs
Screening/Surveillance Colonoscopy	Medicare Parts A and B	ASCs, ambulatory/office-based care, HOPDs

Cost Category – Episode Measures

Radiology groups performing surgical-related procedures may be scored on *certain* episode-based measures such as:

- **Hemodialysis Access Creation:**

36818	Relocation of major upper arm vein with connection to arm artery for hemodialysis
36819	Relocation of upper arm surface vein with connection to arm artery for hemodialysis
36820	Relocation of forearm vein with connection to arm artery for hemodialysis
36821	Relocation of arm vein with connection to arm artery for hemodialysis
36825	Creation of artery-vein connection using vein graft for hemodialysis
36830	Creation of artery-vein connection using tube graft for hemodialysis

- **Revascularization for Lower Extremity Chronic Critical Limb Ischemia:**

37226	Insertion of stent in arteries of leg
37230	Insertion of stent in artery of leg, initial vessel

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Reviewing Cost Feedback

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Cost Feedback

MIPs Timeline: Submission Window

- **January 1st – March 31st**
  - *Preliminary scores based on submission of Quality data, won't fully account for category weighting or bonus points*
- **April – July**
  - *All QPP feedback still preliminary, but scores start changing (Quality benchmarks, category weighting applied)*
- **July**
  - *Final score preview released* ***(COST SCORES and BONUS POINTS!)***
- **August**
  - *Final payment adjustments released, Targeted Review applications* ***OPEN****, Cost Beneficiary Data available on QPP*

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Cost Feedback

Where to find Cost details on QPP

- **Log into QPP/HARP account-** [QPP Sign In (cms.gov)]
- **Navigate to PERFORMANCE FEEDBACK**
  - **Left hand side of navigation bar**

- **Locate TIN and click ‘View Practice Details’**
- **Then click ‘View Group Feedback’**
  - **Right hand side**

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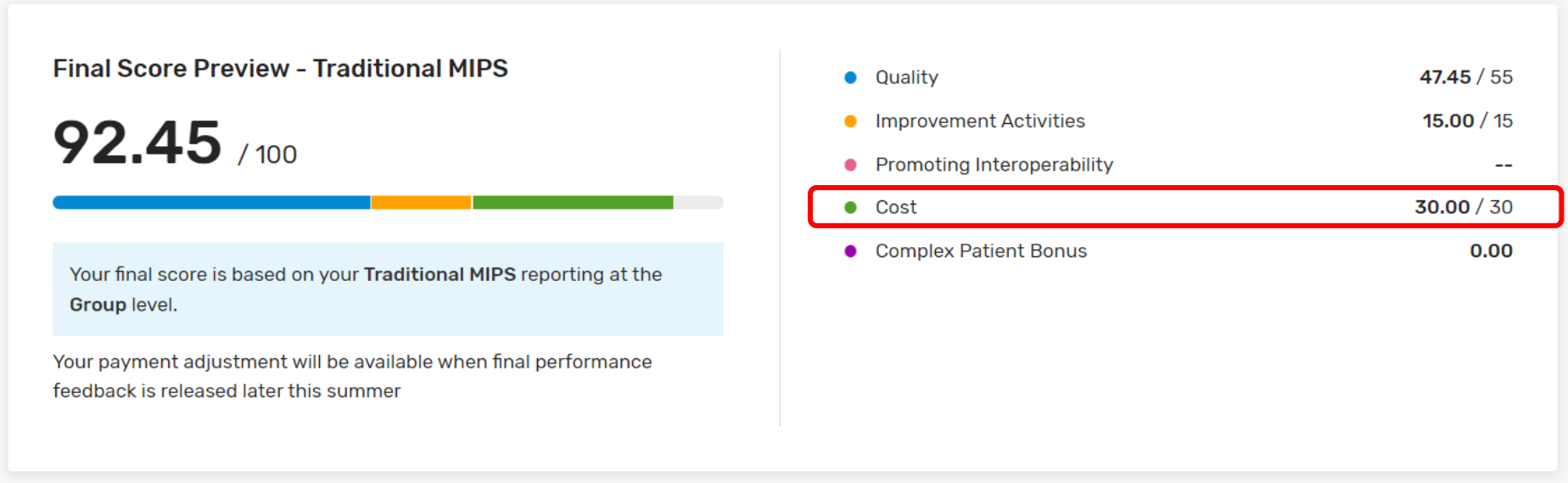
Cost Feedback

Where to find Cost details on QPP



- **<u>Final Score</u> breakdown at the top page**
- ***Category* specific details below**
  - **Scroll to <u>COST</u> and click *'view details'***

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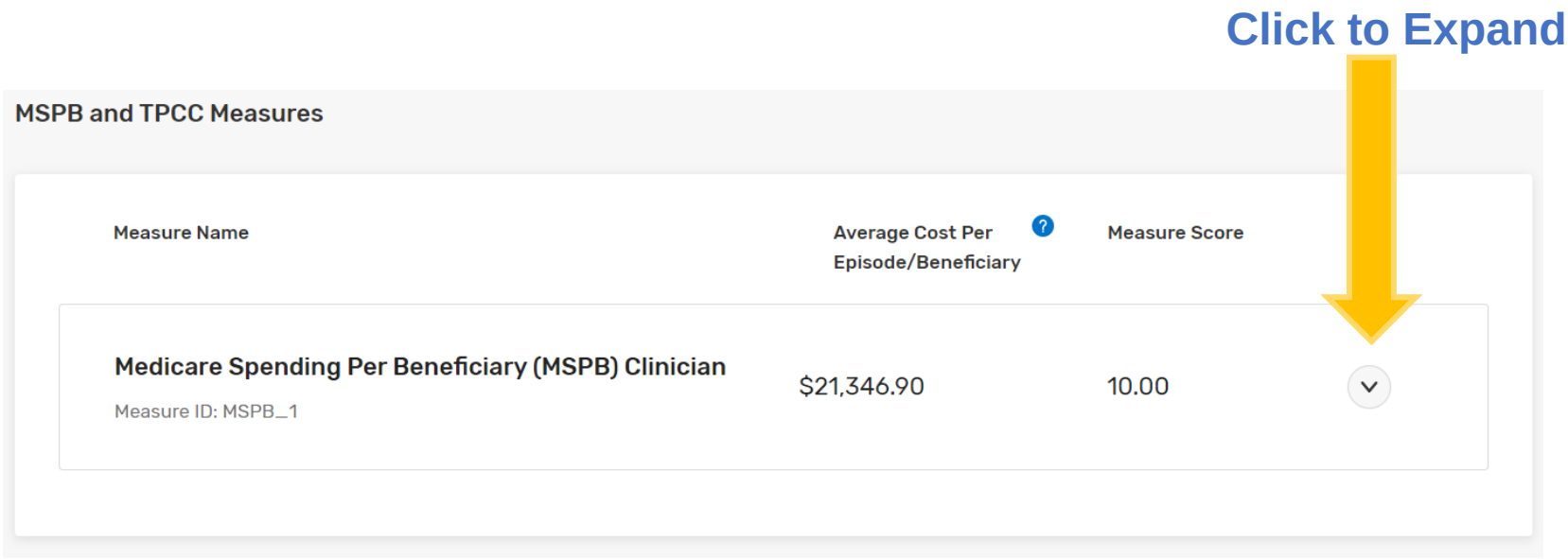
Cost Feedback

Where to find Cost details on QPP



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Cost Feedback

Where to find Cost details on QPP

Medicare Spending Per Beneficiary (MSPB) Clinician $21,346.90 10.00

Measure ID: MSPB_1

Measure Info

The MSPB Clinician measure assesses the risk-adjusted cost to Medicare for services performed as a result of a clinician's care for a patient's inpatient hospital stay during the period 3 days prior to a hospital stay (also known as the "index admission" for the episode) through 30 days after discharge. The measure excludes costs from a defined list of services that are unlikely to be influenced by the clinician's care decisions and are thus considered unrelated to the index admission. In all supplemental documentation, the term "cost" generally means the standardized Medicare allowed amount.

Reporting Period

1/1/22 - 12/31/22

Note : We will not provide HIV/AIDS or mental health data in this file.

Measure Details

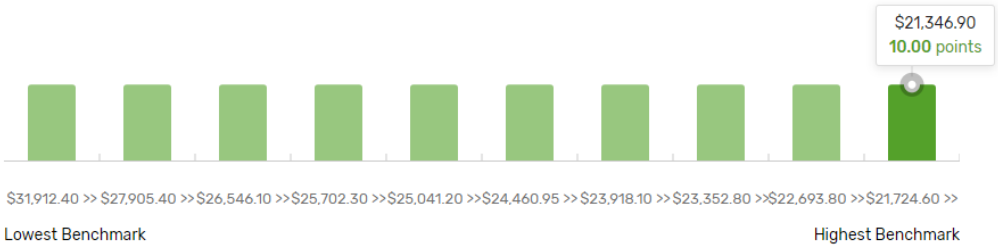
Eligible Episodes	54
MSPB Unadjusted Per Episode Cost	$39,323.53
MSPB Ratio	0.89

Performance Points

Partial Points Attributed	0.00
Points from Benchmark Decile	10.00
Measure Score	**10.00**

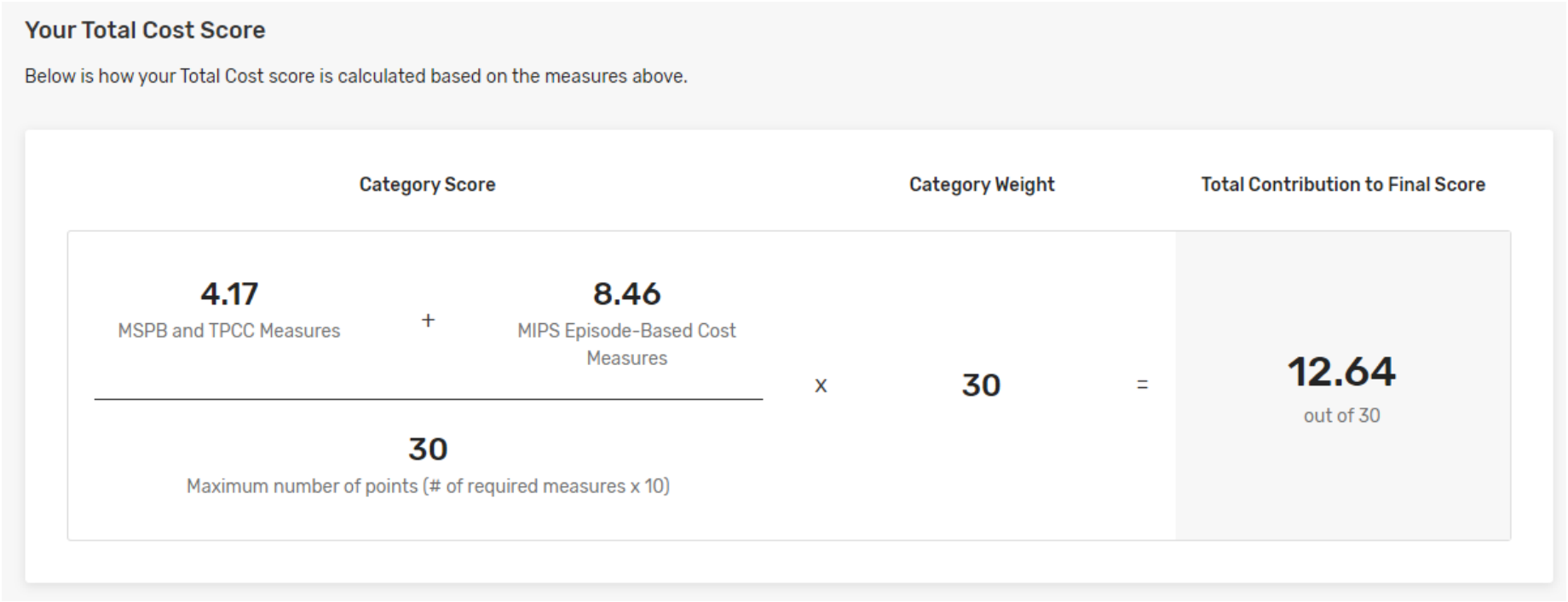
Beneficiary level data available to download from this page…eventually

The green bars below outline the start of each decile value range. The marker displayed on the green bar is the assigned start of the decile score, unless the assigned Cost score value falls below the lowest decile, which results in a score of 1 point.



Cost Feedback

Where to find Cost details on QPP



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What can you do if scored on Cost?

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Cost: What can you do?

Understand the Pitfalls

- **COST is mysterious (for specialties)**
  - Extremely hard to track during performance year
    - *Case-minimum threshold*
  - If you are scored one year, safe to assume you'll be scored the following baring any major changes to methodology
    - *No cost feedback 'recently' (2019, 2020, 2021)*

- **COST is a moving target**
  - *Cost measures use performance period benchmarks calculated months after the performance year is over*
  - *Hard to know what you are up against or pivot*

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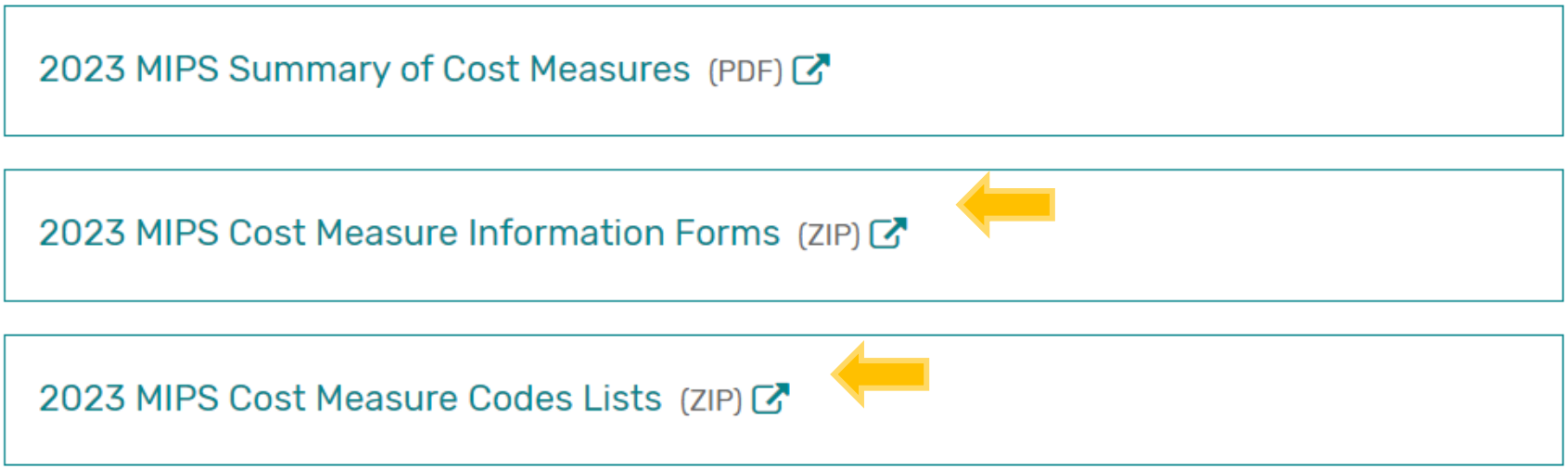
Cost: What can you do?

Review Feedback, Gain Understanding

- **If scored, review feedback available on QPP and attempt to understand *‘why’***
  - *Review beneficiary level data when available later in year*

https://qpp.cms.gov/mips/explore-measures?tab=costMeasures&py=2023



Cost: What can you do?

Dispute with Targeted Review (if possible)

- **Targeted Review applications open when final payment adjustments are released (early August)**
  - *Provides a formal process to dispute results with QPP for any category*
  - *Consolidate supporting evidence, examples, and reasoning into application*
  - *Can result in recalculation of category/final score*
  - *Decisions for targeted review are 'final' so be planful when submitting applications*

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Cost: What can you do?

Share Results with Stakeholders

- **In most cases, Radiology practices are <u>not</u> the ones in *control…***
  - If unable to have COST score re-calculated with TR, be sure to reach out to hospital partners to communicate results
    - *Look for someone in charge of value-based care or quality reporting programs ideally*
  - Interests in controlling costs for Medicare pts should be aligned (ie – Hospital Quality reporting programs, Alternative payment models)

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Cost: What can you do?

Control What You Can

- **Based on feedback, look for opportunity to influence cost improvements**
  - ***Dig deep into that QPP portal!***

- **Consider ways to avoid being scored**
  - ***TPCC – triggered by NP/PA billing e/m***
  - ***Extreme and Uncontrollable Circumstances 'other' application***

- **Score well with QUALITY and Improvement Activities to offset**

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Summary

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Summary

Cost Deep Dive

- **Understand when COST applies**
- **Review QPP Cost Feedback**
  - ***Dispute with Targeted Review if possible***
    - ***Look on ways to influence if not disputable***
- **Plan for multiple final scoring scenarios, Quality and Improvement Activities categories are most 'controllable'**

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Submitted Questions

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Thank you!

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