The Physicians Advocacy Institute’s
Medicare Quality Payment Program (QPP)
Physician Education Initiative

2019 Cost Category Overview
MEDICARE QPP PHYSICIAN EDUCATION INITIATIVE

2019 Cost Category Overview

2019 is the third year of the MACRA Quality Payment Program (QPP), under which physicians may choose to participate in an Advanced Alternative Payment Model (APM) or submit data to the Merit-Based Incentive Payment System (MIPS).

MIPS consolidates and sunsets the previous quality reporting programs by the Centers for Medicare and Medicaid Services (CMS), including the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and the Electronic Health Records (EHR) Incentive program (Meaningful Use), into one program. In 2019, MIPS has four weighted performance categories: quality (45%), based on PQRS; cost (15%), based on VM; promoting interoperability (PI) (25%), previously advancing care information (ACI); and improvement activities (15%).

This resource provides guidance for the cost category for individual, group, and Virtual Group participants.
What are my options for the cost category?

Like 2018, the cost category has a full-year performance period for 2019 which will consist of a 12-month period from January 1, 2019 – December 31, 2019. However, physicians are not required to submit any data on specific cost measures for this category. CMS will use administrative claims data to assess performance in 10 cost measures: the Medicare Spending Per Beneficiary (MSPB) measure, the Total Per Capita Cost (TPCC) measure, and 8 episode-based measures. These 8 episode-based measures are categorized as either acute inpatient medical condition episodes or procedural episodes.

<table>
<thead>
<tr>
<th>Measure Category</th>
<th>Attribution and Case Minimum</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedural Episodes</td>
<td>Attribution to each MIPS EC who renders a trigger services as identified by HCPCS/CPT code. The case minimum would be 10 episodes for these measures.</td>
<td>Elective outpatient percutaneous coronary intervention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Knee arthroplasty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Revascularization for lower extremity chronic critical limb ischemia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Routine cataract removal with intraocular lens (IOL) implantation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Screening/surveillance colonoscopy</td>
</tr>
<tr>
<td>Acute inpatient medical condition episodes</td>
<td>Attribution to each MIPS EC who bills inpatient E/M claim lines during trigger inpatient hospitalization (i.e., a MS-DRG identifying the episode group) under a TIN that renders at least 30% of inpatient E/M claim lines in that hospitalization. The case minimum would be 20 episodes for these measures.</td>
<td>Intracranial hemorrhage or cerebral infarction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Simple pneumonia with hospitalization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ST-elevation myocardial infarction (STEMI) with PCI</td>
</tr>
</tbody>
</table>

Costs for services and items related to an episode may include, but are not limited to: diagnostic services, treatment services, and ancillary items and services directly related to treatment (e.g., anesthesia for a surgical procedure), services following the initial treatment period that may be rendered as follow-up care, etc. Additionally, CMS may include services furnished as a consequence of care, for example, complications, readmissions, unplanned care, and emergency department visits.

CMS has also noted that patients may be assigned to more than one episode group.

How is the cost category scored?

Physicians must meet the case minimum requirements for each measure in order to have the measures count towards the cost category performance score. If the case minimum is not met for a measure, then the cost category weight will be based solely on the remaining measures. If the case minimum is not met for all measures, then the cost category will be reweighted to 0% and
the quality category will be reweighted to 60%, PI weight would be 25% and, the improvement activities weight would be 15%.

The score for the cost category will be determined using an approach that is similar to that used for the quality category measures. Physicians will receive 1-10 points for each of the applicable cost measures based on their relative performance in the measures compared to the measures’ benchmarks. Unlike the quality category, physicians will not automatically receive a minimum number of points for these measures. Additionally, unlike the quality category measure benchmarks, the cost category measure benchmarks are not based on previous year data; cost category measure benchmarks are determined using the performance year data and seeing how physicians performed compared to their peers. Further details on the scoring for the MSPB and TCOC are provided in the appendix.

2019 Cost Performance Category Scoring Example

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

In the example above, the group’s Cost performance category is score is (47.6/70=0.68) which is equal to a Cost performance category percent score of 68%. Because the Cost performance category is worth 15 points in the MIPS final score, this group would earn 10.2 points towards their final score (68 x .15=10.2).

Source: CMS Cost Category Fact Sheet

© 2019 Physicians Advocacy Institute
www.physiciansadvocacyinstitute.org
Where can I go for more information?

For additional information on the cost category, please visit PAI’s QPP Center for resources and tutorials. Additionally, visit CMS’s Cost Category page and CMS’s QPP Resource Library for more information.
Appendix

Medicare Spending Per Beneficiary (MSPB)

Numerator = sum of the ratios of observed to expected costs for all MSPB episodes
Denominator = total number of MSPB episodes

Exclusions:

- Beneficiary not continuously enrolled in both Medicare Parts A and B from 93 days prior to the index admission through 30 days after discharge
- Beneficiary’s death occurred during the episode
- Beneficiary enrolled in a Medicare Advantage plan or Medicare is the secondary payer at any time during the episode or 90-day lookback period
- Index admission for the episode did not occur in a subsection (d) hospital paid under the Inpatient Prospective Payment System (IPPS) or an acute hospital in Maryland
- Discharge of index admission occurred in the last 30 days of the performance period
- Index admission involved in an acute-to-acute hospital transfer (i.e., the admission ends in a hospital transfer or begins because of a hospital transfer)
- Index admission occurs within the 30-day post-discharge period of another MSPB episode
- Index admission inpatient claim indicates a $0 actual payment or a $0 standardized payment

7 Steps for Calculating the MSPB Measure:

1. Define the population of index admissions
2. Calculate payment-standardized episode costs
3. Calculate expected episode costs
4. Exclude outliers
5. Attribute episodes to a TIN-NPI
6. Calculate the MSPB for the TIN-NPI (if reporting as a solo practitioner) or TIN (if reporting as a group or Virtual Group)
7. Report the MSPB measures for the TIN-NPI or TIN

---

Information based on CMS’s Cost Category Measure Specifications available on the CMS QPP Resource Library.

© 2019 Physicians Advocacy Institute
www.physiciansadvocacyinsitute.org
Define Population of Index Admissions
• MSPB episodes include all Medicare Parts A and B claims, and begin 3 days prior to a hospital admission and end 30 days after hospital discharge.

Calculate Payment-Standardized MSPB Episode Costs
• Calculated by summing all standardized Medicare claims payments made during the episode window.
• Episodes are payment-standardized to account for payment factors unrelated to provisions of care, e.g., add-on payments for education and geographic variations.

Calculate Risk-Adjusted Expected MSPB Episode Costs
• Expected costs are calculated using a model based on the CMS Hierarchical Condition Category (CMS-HCC) risk adjustment methodology for Medicare Advantage (MA), with a few differences, and with the inclusion of interactions terms between HCCs and/or enrollment status variables.

Exclude Outliers
• Statistical outliers are excluded to mitigate the effect of high- and low-cost episodes.

Attribute Episodes to TIN-NPI
• Attribution based on the TIN-NPI responsible for providing the plurality of Part B Physician/Supplier services during the index admission.

Calculate MSPB Measure for Each TIN-NPI or TIN
• Measure calculated by (i) calculating the ratio of the standardized observed episode costs to expected episode costs, and (ii) multiplying the average cost ratio across the episodes by the national average episode cost.

Report MSPB Measure for Each TIN-NPI or TIN
• Although the MSPB is attributed at the TIN-NPI, the reporting for the measure can be either at the TIN-NPI (solo practitioner level) or the TIN (group level).
Total Per Capita Costs

Numerator = sum of annualized, risk- & specialty-adjusted Parts A & B costs for attributed beneficiaries
Denominator = number of Medicare beneficiaries attributed to TIN-NPI

Exclusions:

- Beneficiaries not enrolled in both Medicare Part A and Part B for every month during the performance period, unless part year enrollment was result of new enrollment or death
- Beneficiaries were enrolled in a private Medicare health plan for any month during the performance period
- Beneficiaries resided outside the US, its territories, and its possessions during any month of the performance period

7 Steps for Calculating the Total Per Capita Cost (TPCC) Measure:

1. Attribute beneficiaries to TIN-NPI*
2. Calculate payment-standardized per capita costs
3. Annualize costs
4. Risk-adjust costs
5. Specialty-adjust costs
6. Calculate the TPCC measure for the TIN-NPI or TIN
7. Report the TPCC measure for the TIN-NPI or TIN

*The final details of the attribution methodology continue to be refined and described by CMS. There may be some small differences between this attribution methodology and the specific methodology used for other programs. For example, a beneficiary attributed under Voluntary Alignment where allowed (Shared Savings Program and Next Generation ACO) may be attributed for cost category purposes to an ACO non-Participant under the plurality of Part B charges during the index admission. Additionally, timing used for both retrospective and prospective Attribution for Shared Savings Program, Next Generation ACOs, Comprehensive Primary Care Plus (CPC+), ESRD Seamless Care Organizations and other programs may also find differences in individual beneficiary attribution for cost category purposes from the methodology used for those programs.
Step 1: Attribute beneficiaries to TIN-NPI
- Two-step process that takes into account the level of primary care services received and the clinician specialties that performed those services.

Step 2: Calculate Payment-Standardized Per Capita Costs
- Measure is payment-standardized to account for payment factors unrelated to provisions of care, e.g., add-on payments for education and geographic variations.

Step 3: Annualize Costs
- Costs are annualized by dividing the total payment standardized costs for each beneficiary by the fraction of the year the beneficiary had both Medicare Parts A and B coverage.
- This is to account for new enrollees and those who died during the performance period.

Step 4: Risk-Adjust Costs
- Costs risk-adjusted based on CMS-HCC risk score and End Stage Renal Disease (ESRD) status, and then comparing the actual per capita costs with expected per capita costs. and multiply by average non-risk-adjusted cost across all attributed beneficiaries.

Step 5: Specialty-Adjust Costs
- CMS applies a specialty adjustment to account for cost variations across specialties

Step 6: Calculate TPCC Measure
- Measure calculated through Steps 1-5 and equivalent to numerator/denominator

Step 7: Report TPCC Measure for Each TIN-NPI or TIN
- Although the MSPB is attributed at the TIN-NPI, the reporting for the measure can be either at the TIN-NPI (solo practitioner level) or the TIN (group level).