

WELCOME!

We will begin at 12:30 PM Eastern

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QPP Year 4:

Understanding the Cost Performance Category

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Kentucky Regional Extension Center Services

UK's Kentucky REC is a trusted advisor and partner to healthcare organizations, supplying expert guidance to maximize quality, outcomes and financial performance.

Kentucky REC Description



To date, the Kentucky REC's activities include:

- Assisting more than 5,000 individual providers across Kentucky, including primary care providers and specialists
- Helping more than 95% of the Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) within Kentucky
- Working with more than 1/2 of all Kentucky hospitals
- Supporting practices and health systems across the Commonwealth with practice transformation and preparation for value based payment

Physician Services

1. Promoting Interoperability (MU) & Mock Audit
2. HIPAA SRA, Project Management & Vulnerability Scanning
3. Patient Centered Medical Home (PCMH) Consulting
4. Patient Centered Specialty Practice (PCSP) Consulting
5. Value Based Payment & MACRA Support
6. Quality Improvement Support
7. Telehealth Services

Hospital Services

1. Promoting Interoperability (Meaningful Use)
2. HIPAA Security Analysis & Project Management
3. Hospital Quality Improvement Support

Your REC Advisors & Presenters



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QIA



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QIA

QPP Y4: Cost

Merit-Based Incentive Payment System (MIPS) Track

- Overview
- Cost Category Updates

2020 Cost Category Analysis

- Understanding Cost Measures
- Attribution Methodologies

Planning for the Future & Driving Improvement

- Benchmarking
- Driving Improvements & Controlling Cost

Q&A



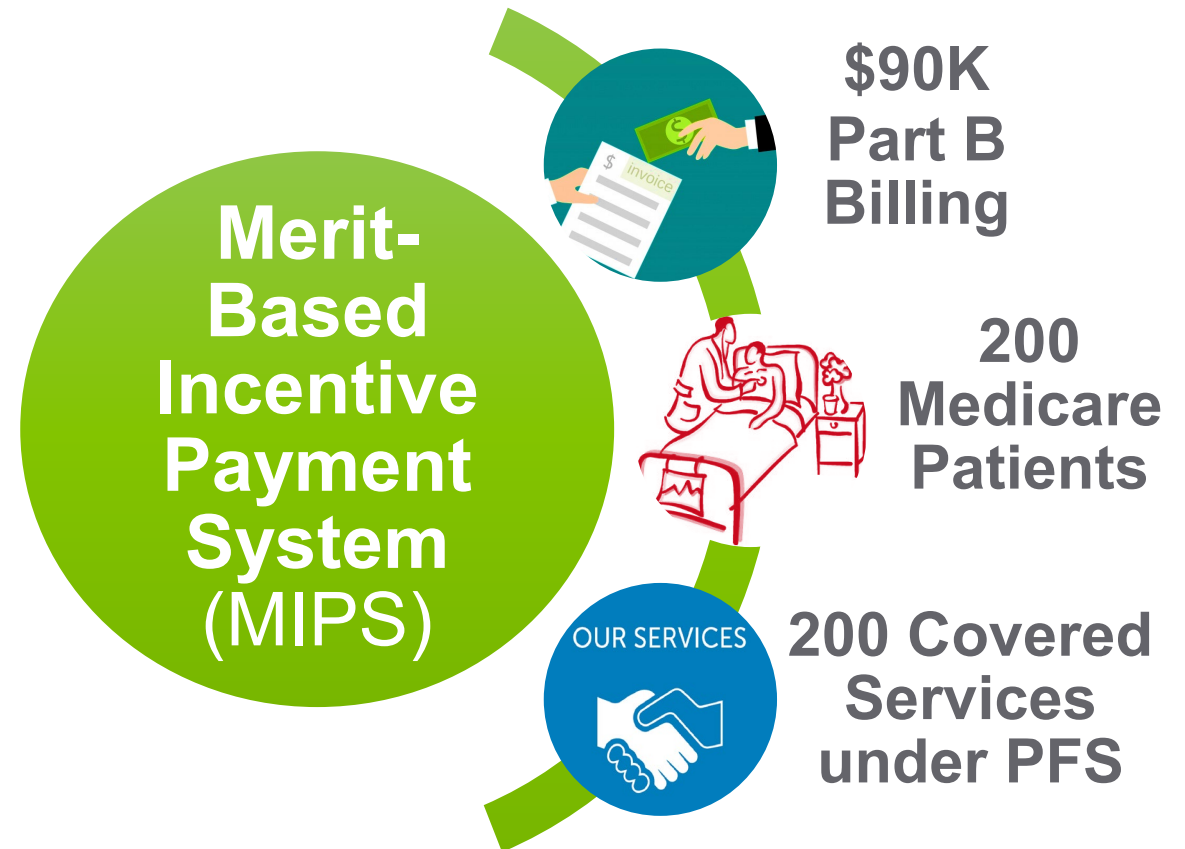
QPP 2020 Merit-Based Incentive Payment System (MIPS) Track Overview & Cost Category Update

QPP Y4: MIPS Clinician Eligibility

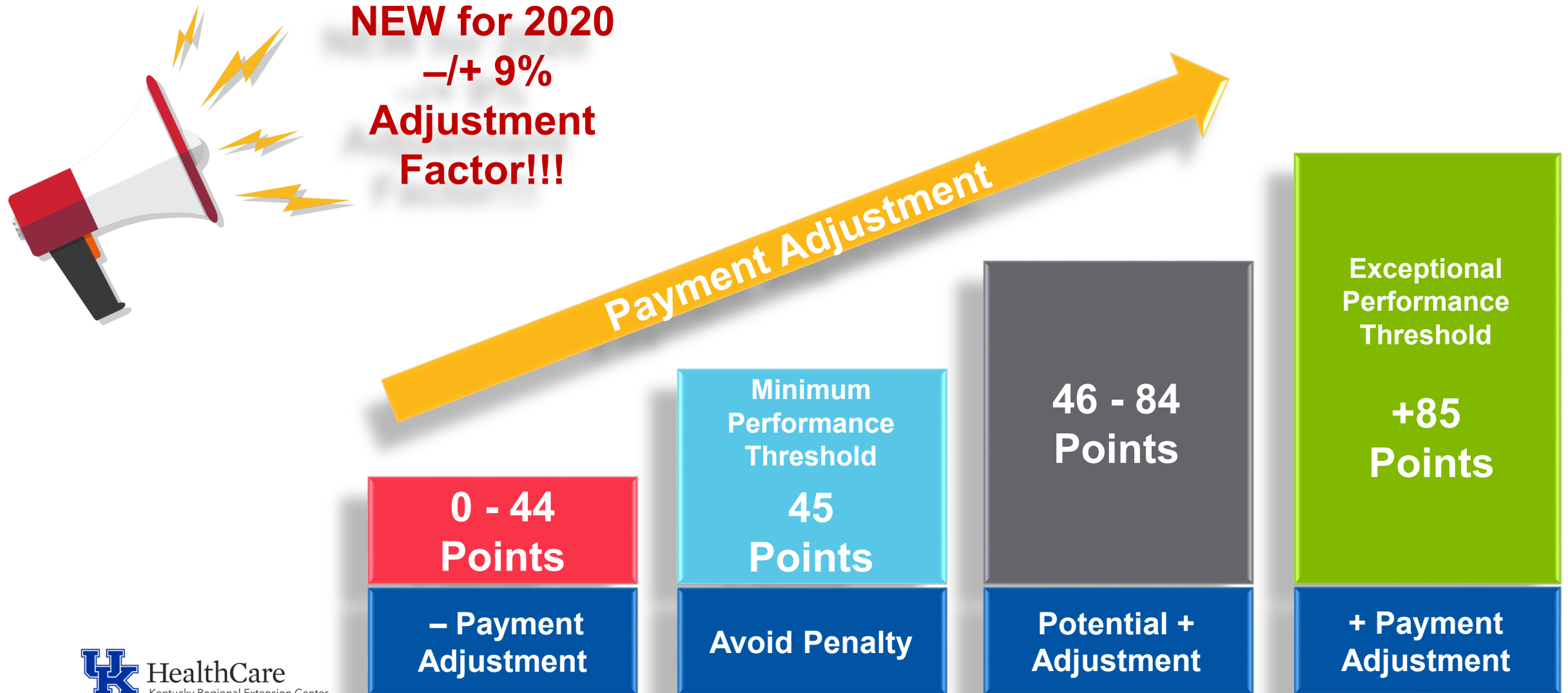
Eligible Clinician Types:

- Physician:
Doctor of Medicine,
Osteopathy, Dental
Surgery, Dental
Medicine, Podiatric
Medicine, &
Optometry
- Osteopathic
Practitioner
- Chiropractor
- PA
- NP
- CNS
- CRNA
- PT/OT
- Qualified Speech-
Language
Pathologist
- Qualified
Audiologist
- Clinical
Psychologist
- Registered
Dietitian or
Nutrition
Professional

QPP Track Eligibility Requirements



QPP Y4: MIPS Thresholds



QPP Y4: MIPS Overview



QPP Y4: Cost Glossary of New Terms

Measure Information Form:

- Formerly known as Measure Specification Sheet.

Cost Measure Code List:

- Resource with all Cost measure information, including: Attribution, Exclusions, Trigger Codes, and Risk Adjustment Codes.

MSPBC – MS-DRG (Medicare Severity – Diagnosis Related Group):

- System of classifying a Medicare patient's hospital stay into various groups in order to facilitate payment of services.

TPCC – Candidate Event:

- Start of a primary care relationship between clinician & beneficiary; identified by the occurrence of two Part B Physician/Supplier (Carrier) claims with particular CPT/HCPCS codes. (E&M primary care services and primary care services).

TPCC – Risk Window:

- Begins on the date of the candidate event and continues until one year after that date. A beneficiary's costs are attributable to a clinician during months where the risk window & measurement period overlap.

QPP Y4: Why Consider Cost?

Quality:

Added:

New Measures &
Specialty Measure
Sets

Removed/Altered:

125 Measures
Increase of Data
Completeness = 70%

Cost:

Measure Alterations:

- MSPBC
- TPCC

Attribution:

Set at Measure level

Added:

10 New Episode-based
Measures

IA:

Removed:

15 Activities

Added/Modified:

9 Activities

50% of ECs in Group
MUST Perform Activity

PI:

Removed/Modified:

Bonus Measure(s)
Hospital-Based as 75%
or More of ECs
Under TIN

Why It Matters...

Most Measures
Updated Impacting
Num/Den & Workflows

Pull Measure Spec
Sheets to Verify

Every Measure
Impacted

Patient-Relationship
Process

Expanded Measures

Increased
Documentation Burden

Requires Added
Prep/Planning

Reduced Bonus Opp.

105 Possible Pts.

Expanded Flexibility for
Hospital-Based ECs

QPP Y4: Cost Measures Overview

	Type	Cost Measure	Adjustments	Case Minimum	Data Source(s)
Cost Composite Score	MSPBC	Medicare Spending Per Beneficiary Clinician (MSPBC)	<ul style="list-style-type: none"> ✓ Payment Standardized ✓ Risk Adjusted 	35 Episodes	Medicare Part A & B Claims
	TPCC	Total Per Capita Cost (TPCC)	<ul style="list-style-type: none"> ✓ Payment Standardized ✓ Risk Adjusted ✓ Specialty-Adjusted 	20 Medicare Patients	Medicare Part A & B Claims
	Episode-Based Measures (18 Total)	13 Episode-Based Procedural Measures 5 Episode-Based Acute-Inpatient Measures	<ul style="list-style-type: none"> ✓ Payment Standardized ✓ Risk Adjusted 	Procedural 10 Episodes Acute-Inpatient 20 Episodes	Medicare Part A & B Claims



Final Score:

15% for 2020

TBD for 2021

30% for 2022 & Beyond



Submission:

No Attestation Required

QPP Y4: Cost Measure Updates

Medicare Spending per Beneficiary Clinician

Updated the attribution methodology

Medical vs surgical episode

Added service exclusions

Total per Capita Cost

Updated attribution methodology

New terms: Candidate Event & Risk Window

Multiple TINs to one beneficiary

Service category & specialty exclusions

Risk Adjustment Methodology Change

Monthly Cost Evals

Episode-Based Measures

Attribution at Measure Level:

- Procedural Measures
- Inpatient Measures

No change in case thresholds

Understanding the Cost Category

Cost Performance
Measures

Cost Measure
Attribution

Calculating Cost
Measures

Using
Performance
Feedback



QPP 2020: MIPS Cost Category Analysis

Cost Analysis: MSPBC Patient Attribution

Medical

TIN Billing \geq 30% of IP
E/M services

Any clinician in TIN
billing \geq 1 IP E/M service

Surgical

Clinician(s) performing
any related surgical
procedure during IP stay

Billing TIN for procedure

Cost Analysis: Medicare Spending per Beneficiary Clinician

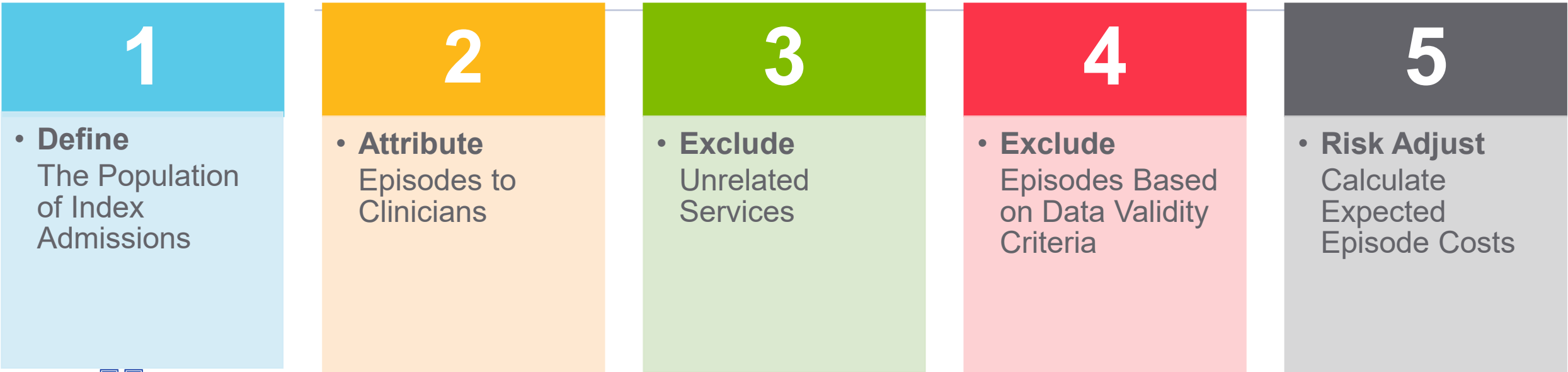
Episode Window

3 days prior to the index admission & ends 30 days after discharge



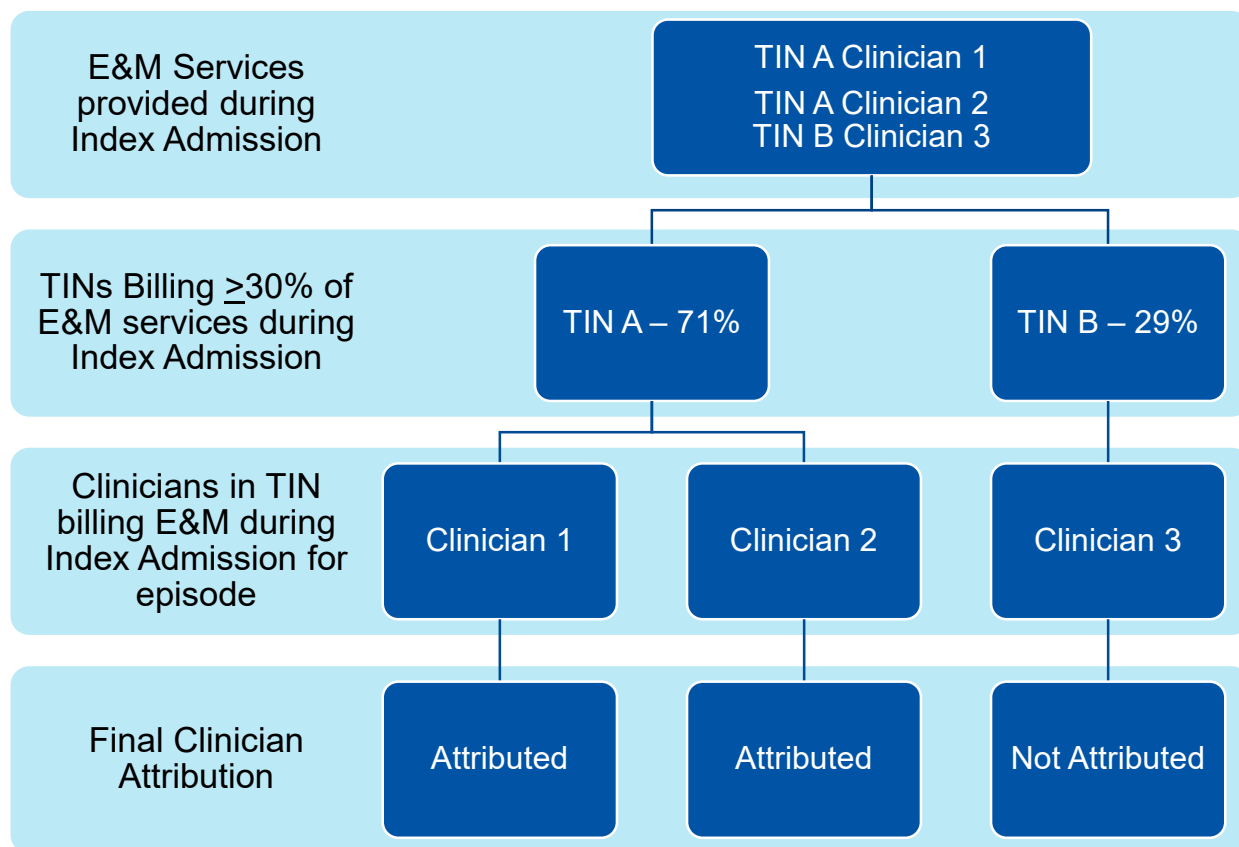
Measure Overview

Assesses the cost to Medicare of services provided to a beneficiary during an episode, which comprises the period immediately prior to, during & following the beneficiary's hospital stay, with exceptions for services identified as unlikely to be influenced by the clinician's care decisions.

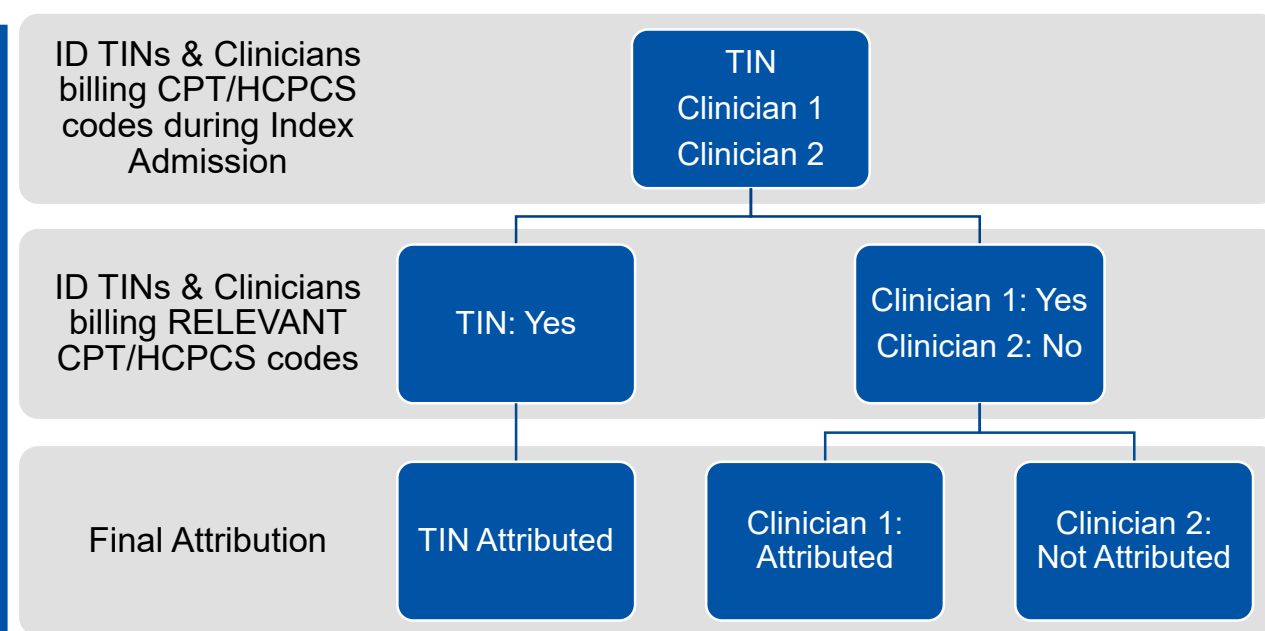


Cost Analysis: MSPBC Clinician Attribution Examples

Medical MS - DRG Attribution Example:



Surgical Attribution Example:



Cost Analysis: Total Per Capita Cost

Candidate Events

Consist of an evaluation & management (E&M) primary care service paired with one or more additional primary care service(s) that together trigger the opening of a risk window.

Risk Windows

Candidate Event



1 Year after Date of
Candidate Event

Measure Overview

A payment-standardized, risk-adjusted & specialty-adjusted measure that evaluates the overall cost of care provided to beneficiaries attributed to clinicians, as identified by a unique TIN & NPI combination (TIN-NPI) & clinician groups, as identified by a unique TIN.

1

- **Identify** Candidate Events

2

- **Exclude** Clinicians from Attribution

3

- **Construct** Risk Windows

4

- **Attribute** Beneficiary Months to TINs/TIN-NPIs

5

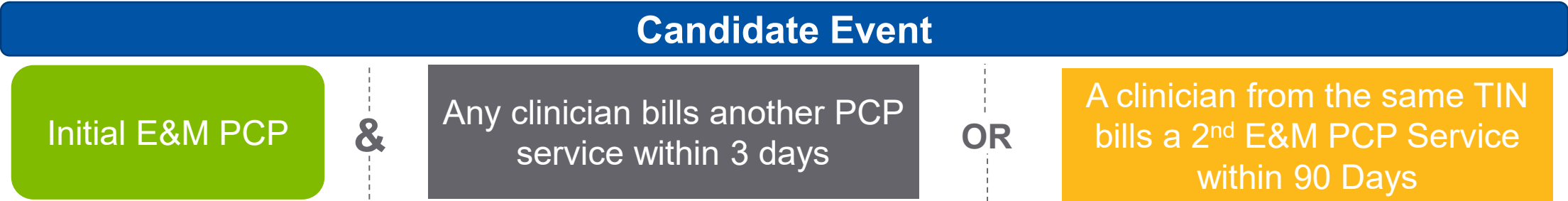
- **Calculate** Payment-Standardized Monthly Observed Costs

6

- **Risk & Specialty Adjust** Payment-Standardized Monthly Costs

Cost Analysis: TPCC Attribution Examples

Clinician: Specialty	Candidate Events	Exclusions	TIN-NPI Attribution
A: Cardiology	Candidate Event 1 Candidate Event 2	Excluded From Global Surgery Service	Clinicians A & B will not be Attributed
B: Optometry	Candidate Event 3 Candidate Event 4	Excluded From Due Optometry Specialty	
C: Family Practice	Candidate Event 5	No Exclusions Apply	Clinician C will be Attributed Event 5
D: Geriatric Medicine	Candidate Event 6 Candidate Event 7	No Exclusions Apply	Clinician D will be Attributed Event 6-7



Cost Analysis: Episode-Based Cost Measures

Procedural Episodes

- 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
- Acute Kidney Injury Requiring New Inpatient Dialysis
- Elective Primary Hip Arthroplasty
- Femoral or Inguinal Hernia Repair
- Hemodialysis Access Creation
- Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels
- Lumpectomy Partial Mastectomy, Simple Mastectomy
- Non-Emergent Coronary Artery Bypass Graft (CABG)
- Renal or Ureteral Stone Surgical Treatment

Triggering
Code

14 Day
Post
Trigger

Episode Window

Cost Analysis: Procedural Episodes Example

Episode Window



Measure Overview

The **Screening/Surveillance Colonoscopy*** cost measure represents the cost to Medicare for the medical care furnished to a beneficiary during an episode of care for screening or surveillance colonoscopy procedure.



Cost Analysis: Procedural Episode Attribution

CMS attributes the episode to any clinician who bills the code that triggers the episode.

Episode-based Measure Attribution

Pre-Trigger Period
(if applicable)

Post-Trigger Period

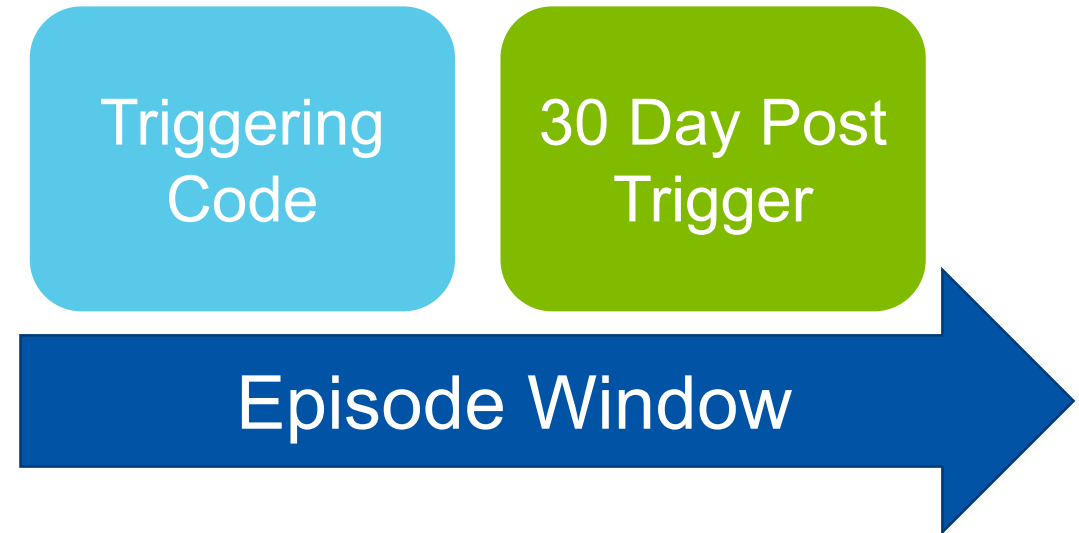
Attribution



Cost Analysis: Acute Inpatient Episodes

Acute Inpatient Medical Condition Episodes

- Intracranial Hemorrhage or Cerebral Infarction Acute
- Simple Pneumonia with Hospitalization
- ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)
- Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
- Lower Gastrointestinal Hemorrhage (applies to groups only)



Cost Analysis: Acute Inpatient Episodes Example

Episode Window



Measure Overview

The **Simple Pneumonia with Hospitalization*** cost measure represents the cost to Medicare for the medical care furnished to a beneficiary during an episode of care for inpatient treatment for simple pneumonia.



Cost Analysis: Acute Inpatient Episode Attribution

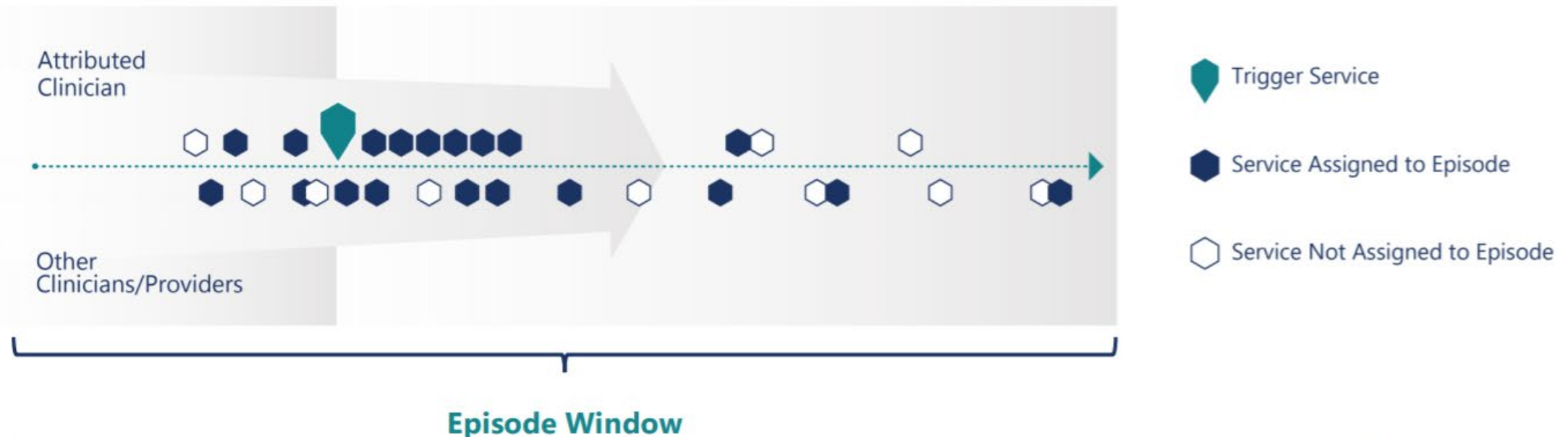
1. Attributed to the TIN billing at least 30 percent of inpatient E/M services on Part B physician/supplier claims during the inpatient stay.
2. Then attributed to any clinician in that TIN who billed at least one inpatient E/M service during the inpatient stay.

Episode-based Measure Attribution

Pre-Trigger Period
(if applicable)

Post-Trigger Period

Attribution





Planning for the Future & Driving Improvement

Cost Planning: Performance Benchmarking



Scored on each cost measure that meets or exceeds minimum case volume



Achievement points assessed by comparing performance to benchmark

- Benchmarks come from current performance period (**NOT historical benchmarks**)



Must meet minimum case volume & be scored on one measure to receive score for the category



Cost Planning: Cost Category Scoring Example

Measure	Points Earned	Total Possible Points
Medicare Spending Per Beneficiary Clinician (MSPBC)	8.1	10
Total Per Capita Cost (TPCC)	6.8	10
Elective Outpatient PCI	3.2	10
Knee Arthroplasty	Not Scored	N/A
Revascularization for LE Chronic Critical Limb Ischemia	Not Scored	N/A
Routine Cataract Removal w/ IOL Implantation	Not Scored	N/A
Screening/Surveillance Colonoscopy	4.2	10
Intracranial Hemorrhage or Cerebral Infarction	6.9	10
Simple Pneumonia w/ Hospitalization	1.5	10
STEMI w/ PCI	7.7	10
TOTAL POINTS	38.4	70

$38.4/70 = 0.54$ (Category Raw Score)

0.54×15 (Category Weight) =

8.1 Cost Points

Driving Improvement: Tips & Tricks



Review 2018 & 2019 Feedback Reports



Track high acuity patients to manage costs



Review trigger code list



Monitor co-morbidities of patient population



Field Testing: To participate or not to participate?

Driving Improvement: Planning & Action Steps

Review
Measure
Information
Sheets

Familiarize
Measure
Attribution
Methodology

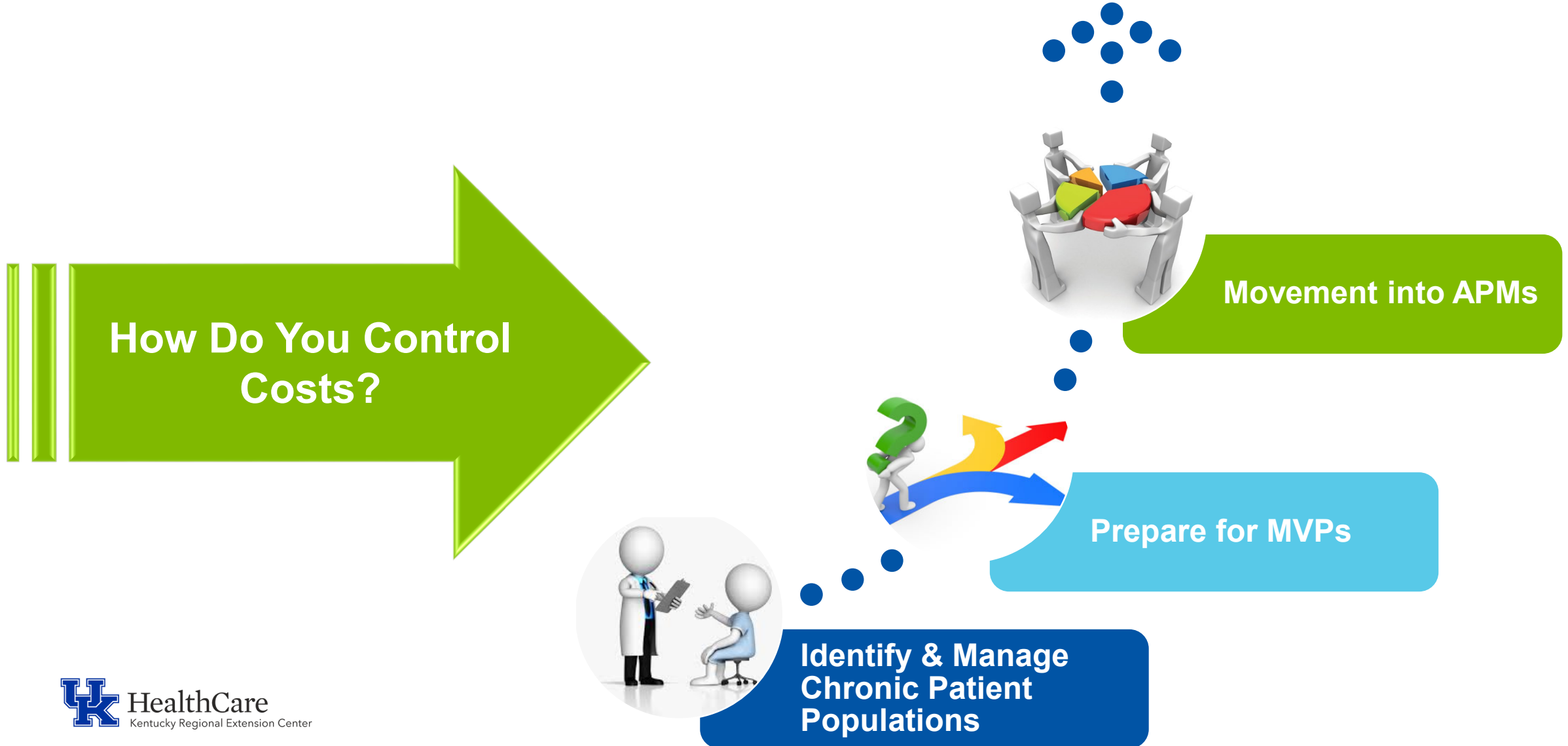
Analyze Past
Cost
Performance

Confirm
Coding/Billing
Practices

Consider
Relevant QI
Improvement
Processes



Driving Improvement: Controlling Cost



Questions



Please submit
your questions
in the Q&A box!

Upcoming QPP Webinars

6/18/20 @ 12:30 (Eastern)

- QPP Y4: Kentucky REC Can Help You Improve Your QPP Performance
- Open to Public

July TBD @ 12:30 (Eastern)

- PI & IA Category Deep Dives
- Client ONLY Series

Contact Us



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